Commonwealth of Kentucky

State Innovation Model (SIM) Model Design Grant

Value-based Health Care Delivery and Payment Methodology Transformation Plan

September 2015

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Preface

This draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan* is the second draft component developed as part of Kentucky's broader State Innovation Model (SIM) Model Design and final deliverable State Health System Innovation Plan (SHSIP). The first draft component, the draft Population Health Improvement Plan (PHIP), was submitted to the Centers for Medicare & Medicaid Services (CMS) after broad stakeholder review on May 29, 2015.

The draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan* focuses primarily on the proposed value-based delivery system and payment reforms being considered as part of the Commonwealth's Model Design. This draft has been developed after more than seven months of direct stakeholder input, the creation of guiding principles, and facilitated workgroup sessions targeted at discussing and refining these delivery system and payment reform strategies. The concepts and initiatives in this draft have primarily been discussed in the Kentucky SIM Integrated & Coordinated Care and Payment Reform workgroups. In addition, the input provided and the guiding principles and strategies developed by the Quality Strategy/Metrics, Health Information Technology (HIT) Infrastructure, and Increased Access workgroups will directly support the value-based components of this draft submission.

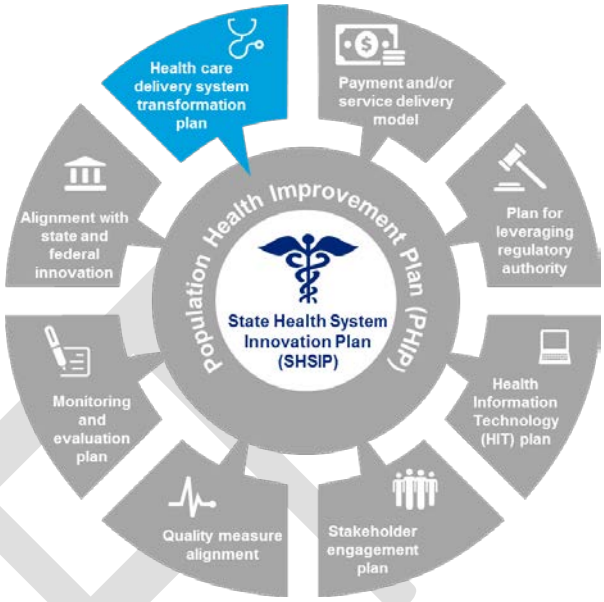

Figure 1: State Health System Innovation Plan Components

To date, stakeholders have participated in panel discussions and given presentations on existing programs, and have emphasized the need for strategies and regulatory/policy levers that increase access to care in Kentucky, with a focus on rural areas. Stakeholders have also identified criteria for selecting quality measures with a focus on improving population health and have developed a five-pronged HIT plan strategy for the SIM initiatives. Each of the elements depicted in Figure 1 will be further developed into standalone sections of the broader SHSIP. The Kentucky Cabinet for Health and Family Services (CHFS) looks forward to continuing its stakeholder engagement process and gathering input into these sections and the broader SHSIP as it comes together into a cohesive Model Design.

Baseline Health Care Landscape

A key tenet of Kentucky's health care reform strategy is to build on the many initiatives already underway to create a plan that addresses the key health care challenges the Commonwealth currently faces. The health care landscape in Kentucky is unique in many respects, and it is important to have a thorough understanding of population demographics, the health insurance landscape, and existing health reform activities prior to designing a plan for payment and delivery system transformation.

Population Demographics

The age of the Kentucky population is nearly identical to that of the United States (U.S.), as shown in Figure 2. However, there has been a shift in the aging trend between the 2000 and 2010 census. Data indicates that the median age of the population increased from 35.9 years to 38.1 years during this decade (University of Louisville, 2015). This is compared to an increase from 35.3 to 37.2 for the U.S. population as a whole (United States Census Bureau, 2011). More detailed age data, shown in Table 1, indicate that this increase in the median age could be due to a higher increase in the percentage of the population aged 70 to 79. The percentage of growth in these age ranges is higher than the national average. Additionally, the percentage of individuals between the ages of 15 and 30 is increasing at a significantly slower pace than the rest of the population in the U.S. Because age is a primary driver of health care expenditures, per capita health care spending should be comparable to that of the U.S. This is true, with per capita health care expenditures in Kentucky totaling $6,596 in 2009 compared to a national average of $6,815 (Kaiser Family Foundation, 2009).

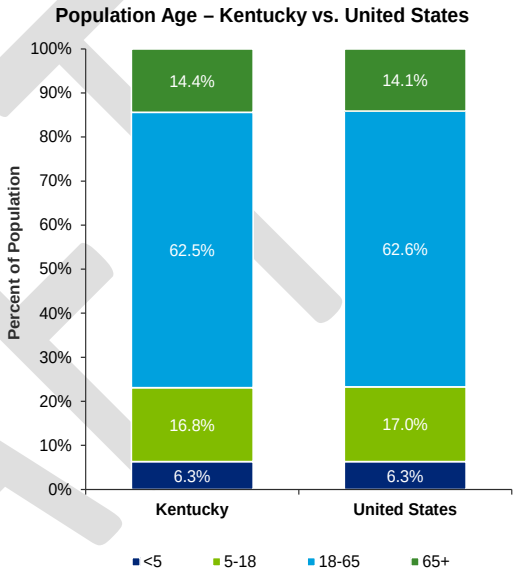

Figure 2: Age of Kentucky Population vs. U.S. Population

Age	2000 Census	2010 Census	KY Percent Change	U.S. Percent Change
0 - 4	265,901	282,367	**6.19%**	**5.35%**
5 - 9	279,258	282,888	**1.30%**	**-0.98%**
10 - 14	279,481	284,154	**1.67%**	**0.73%**
15 - 19	289,004	296,795	**2.70%**	**9.00%**
20 - 24	283,032	289,968	**2.45%**	**13.83%**
25 - 29	281,134	285,296	**1.48%**	**8.88%**
30 - 34	286,974	280,920	**-2.11%**	**-2.67%**
35 - 39	321,931	285,411	**-11.34%**	**-11.13%**
40 - 44	320,734	291,251	**-9.19%**	**-6.91%**
45 - 49	293,976	323,642	**10.09%**	**13.02%**
50 - 54	262,956	319,455	**21.49%**	**26.80%**
55 - 59	204,483	288,027	**40.86%**	**46.00%**
60 - 64	168,112	250,966	**49.29%**	**55.64%**
65 – 69	144,671	185,664	**28.34%**	**30.44%**
70 - 74	129,272	139,650	**8.03%**	**4.75%**
75 – 79	104,760	105,392	**0.60%**	**-1.32%**
80 - 84	67,829	78,313	**15.46%**	**16.14%**
85+	58,261	69,208	**18.79%**	**29.57%**

Table 1: Kentucky Population and Aging Trends

The median household income in Kentucky is approximately 19 percent less than the national median household income, and the percentage of the population living below the Federal Poverty Level (FPL) is 18.8 percent as compared to 15.4 percent nationally. On a per capita basis, the average Kentucky income is $23,462, which is approximately $5,000 less than the national average of $28,155 (United States Census Bureau, 2015). These differences are more pronounced in certain rural parts of the state, such as eastern Kentucky, due to economic hardships caused by a decline in the coal industry.

Kentucky's unemployment rate has been trending with the overall unemployment rate in the U.S. since the beginning of 2014. Despite being slightly higher than the national average during the five months between August and December 2014, unemployment rates dropped in every county in Kentucky during three of the months (August, September, and October 2014) – the first time this has occurred since unemployment records have been maintained (United States Department of Labor: Bureau of Labor Statistics, 2015).

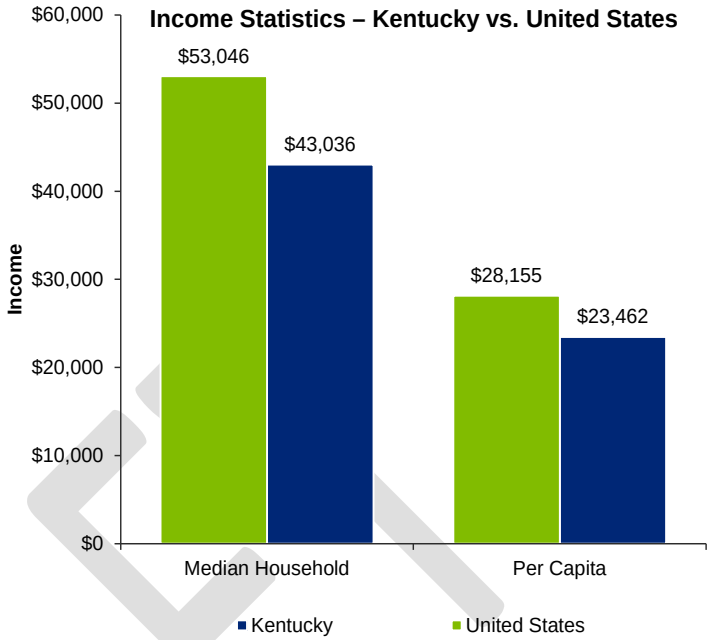

Figure 3: Kentucky Incomes Statistics vs. United States

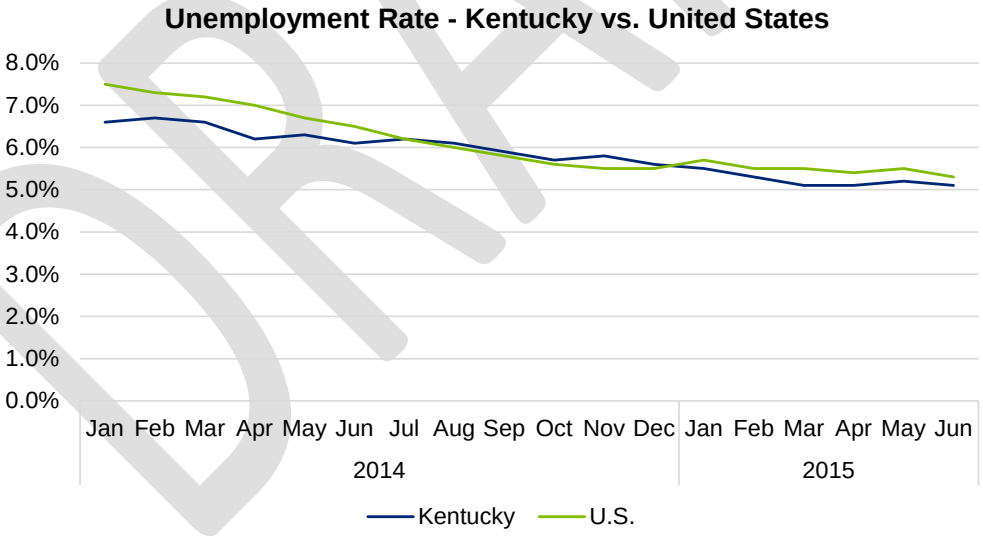

Figure 4: Unemployment Rate – Kentucky vs. United States

Figure 5 illustrates Kentucky's educational achievement between 2009 and 2013. In general, Kentucky's levels of educational attainment have been slightly lower than the U.S. average in terms of high school and college graduates. According to the Centers for Disease Control and Prevention (CDC), lower education and income levels are associated with higher rates of chronic disease (CDC, 2012).

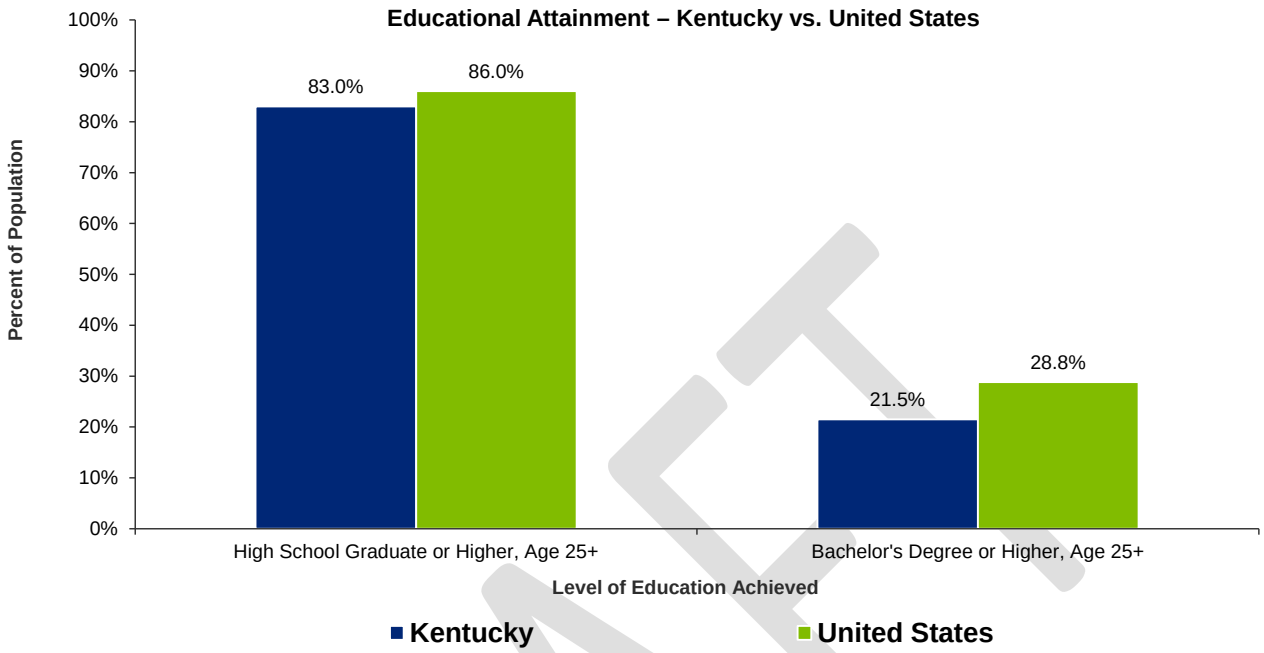

Figure 5: Level of Education Attainment – Kentucky vs. United States

Health Insurance Coverage

Despite the economic and population health issues challenging Kentucky, the Commonwealth has recently experienced a number of successes in its health insurance marketplace. This is primarily due to the decision by Governor Steve Beshear to expand Medicaid to individuals earning up to 138 percent of the FPL, as well as his decision to establish a state-based health insurance exchange, known as kynect. The successful rollout of these two initiatives has resulted in the second largest decrease in the uninsured rate in the country, with approximately 9.8 percent of citizens uninsured as compared to 20.4 percent prior to Medicaid expansion and the implementation of kynect (Witters, 2015).

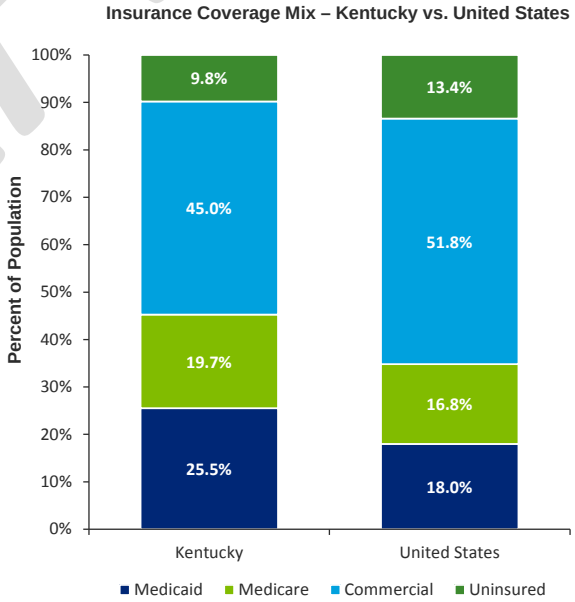

Figure 6: Insurance Coverage Mix in Kentucky

The insurance mix in Kentucky as compared to the U.S. reflects the per capita income disparity in Kentucky, as approximately 25 percent of Kentucky's population is enrolled in Medicaid compared to 18 percent nationally (Anderson, 2015; Kaiser Family Foundation, 2012). Also contributing to this fact is Governor Beshear's decision to expand Medicaid. As a result of policy decisions and low population incomes, Medicaid is the largest individual payer in Kentucky, while Medicare is the second largest[1] (Kaiser Family Foundation, 2012).These public programs combine to cover more than 45 percent of the Kentucky population, which is equivalent to the population covered by commercial carriers. The commercial

[1] 2015 Medicare enrollment numbers are projected, as actual figures are not currently available. Estimates for 2015 enrollment were made by applying enrollment growth projections in CMS's *National Health Expenditures Projection Report 2012-2022* to 2012 enrollment figures.

coverage in Kentucky is lower than the overall U.S. commercial coverage by about seven percent[2]. Within the commercial insurance category, there are two primary carriers that comprise about 80 percent of membership in Kentucky – Anthem and Humana. Anthem is the larger of these two insurers, with 53 percent of the commercial population enrolled in its health plans. Humana, Kentucky's second largest commercial carrier, has approximately 27 percent market share. The remaining 20 percent of the commercial insurance market is fragmented, with nine carriers each owning a small portion of the market (Kentucky Department of Insurance, 2015).

Of the 362,041 commercial plan subscribers in Kentucky, 50,243 (or approximately 14 percent) were purchased on Kentucky's health insurance exchange. Another 27 percent of the plans were purchased outside the exchange. The remaining policies were either considered grandfathered or grandmothered plans[3] (Kentucky Department of Insurance, 2015).

The new influx of Kentuckians with access to health care via Medicaid expansion and kynect underscores the imminent need to adopt payment and service delivery reforms that seek to maximize the value consumers receive for health services, with a sharp focus on improving population health outcomes.

Health Care Workforce Profile

The Commonwealth funded a workforce capacity study in 2013, which surveyed the existing landscape of health care providers throughout Kentucky and provided estimates for the number of providers that would be needed to keep up with future demand (Deloitte, 2013). The findings of the report indicated that in 2012, Kentucky needed an additional 3,790 full time Primary Care Providers (PCPs) and specialists. The study estimated that 61 percent of these providers were needed in rural areas. The rural challenge in Kentucky is worth noting, as the Commonwealth currently ranks 43rd out of 50 states in terms of being the most rural, with 41.6 percent of its population living in a rural area (United States Census Bureau, 2010).

The study indicated that with Medicaid expansion, the additional unmet need for PCPs was an estimated 256 full-time equivalents (FTEs), with approximately 63 percent of the need coming from rural counties. The report also identified the need for an additional 612 FTE dentists in 2012. The shortage of dental providers in 2012 was also more pronounced in some rural counties, with three counties not appearing to have any practicing dentists, and other counties needing to increase dental providers by over 100 percent in order to meet current demand. In addition to PCPs and dentists, the report also outlined FTE needs for the following provider types:

Provider Type	FTE Needs
Advanced Practiced Registered Nurses (APRNs)	148
Physician Assistants (PAs)	296
Registered Nurses (RNs)	5,635
Licensed Practical Nurses (LPNs)	688
Optometrists	269
Mental Health Providers (MHPs)	1,638

Table 2: Kentucky Health Care Provider FTE Needs

The number of FTEs shown for the provider types in Table 2 are a particularly important issue to address, given Kentucky's emphasis on primary care and expanding care teams in its SIM reform initiatives. The study identified and prioritized 11 opportunities the Commonwealth could pursue in an effort to address its workforce needs. Some of these opportunities align with the reform initiatives being proposed in the SHSIP; therefore, it is accurate to say that a plan is in place to begin making progress on Kentucky's workforce needs.

[2] For the purposes of this report, commercial insurance figures were estimated to be the remaining population that is not uninsured or covered by either Medicaid or Medicare.

[3] ***Grandfathered Plans*** are benefit plans in which an individual was enrolled on March 23, 2010, regardless of whether the individual later renews coverage. Grandfathered plans are required to meet some, but not all, of the reforms contained in the Affordable Care Act (ACA). ***Grandmothered Plans*** are non-grandfathered benefit plans that must have been in existence on October 1, 2013. They include some but not all of the ACA features. These plans can only be sold as a renewal policy. They cannot be sold as a new policy.

Existing Delivery System and Payment Reforms in Kentucky

Kentucky has a long history of implementing health care reform efforts focused on improving the health of Kentuckians, including the implementation of a statewide Medicaid managed care program in 2011, the establishment of kynect in 2013, and the expansion of Medicaid to individuals earning up to 138 percent of the FPL in 2014. Additionally, health care reform efforts are occurring at the system of care and provider levels in Kentucky.

Both public and private health care organizations operating in Kentucky began making advances in care delivery and provider payment reform prior to the Commonwealth's SIM Model Design award in January 2015. The combination of many state-based reform initiatives and the participation by Kentucky providers and health systems in multiple national programs funded through CMS has put Kentucky on a unique path towards health system transformation.

The following section highlights the existing landscape in Kentucky and how the Commonwealth's payers, providers, and communities have embraced value-based care in their organizations. The high level of effort demonstrates Kentucky's commitment to quality care beyond just the state level and provides for a broad, motivated stakeholder base to advance the SIM initiatives.

The following sections are designed to outline examples of known activities in Kentucky and are not intended to be a comprehensive view of stakeholder efforts and/or subjective representations of stakeholder organizations. This information was obtained through: (1) research into the health care market in Kentucky, and (2) stakeholder outreach, including a stakeholder inventory survey released to SIM stakeholders in June 2015 and panel presentations at SIM workgroup meetings between March and July 2015.

Patient Centered Medical Home (PCMH) and Other Primary Care Models

National Committee for Quality Assurance (NCQA) Recognition

NCQA PCMH recognition is currently the most widely-used method to evaluate a primary care practice's progress in establishing true medical homes for its patients (NCQA, 2014). The PCMH model has become increasingly common across the service delivery landscape, as evidenced by the models tested in all six of the Round One SIM Model Test states. This program recognizes clinician practices functioning as medical homes that use systematic, patient-centered, and coordinated care management processes. Nearly every state and the District of Columbia have practices recognized for their use of the NCQA's PCMH certification criteria in their PCMH programs. As depicted in Figure 7, as of September 2014, Kentucky had over 200 PCMH-recognized clinicians, as well as 21-60 PCMH sites in operation statewide. Those numbers continue to grow.

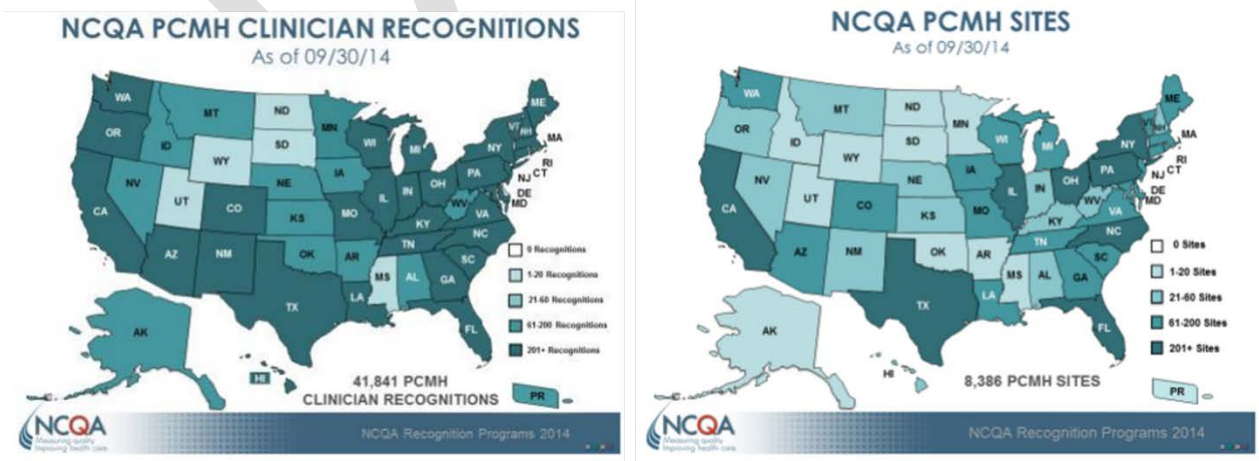

Figure 7: NCQA PCMH Clinician and Sites Recognitions (2014)

As the Commonwealth works to define the role and prominence of the PCMH models within its delivery system transformation plan, it will be important to consider and incorporate the wide variety of PCMH-like activities occurring across the state.

CMS' Comprehensive Primary Care Initiative (CPCI)

The CMS CPCI is a four-year multi-payer initiative designed to strengthen primary care. CMS is collaborating with commercial and state health insurance plans in seven U.S. regions to offer population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "comprehensive" primary care functions. These five functions are: (1) risk-stratified care management; (2) access and continuity; (3) planned care for chronic conditions and preventive care; (4) patient and caregiver engagement; and (5) coordination of care across the medical neighborhood (CMS CPCI, 2015).

Northern Kentucky providers in Boone, Campbell, Grant, and Kenton counties are currently participating in CPCI in the *Ohio & Kentucky: Cincinnati-Dayton Region*, one of CMS' seven test regions. Specifically, St. Elizabeth Healthcare operates 14 of the 76 CPCI practice sites within this region, which is a region that serves approximately 45,000 Medicare and Medicaid beneficiaries (CMS CPCI, 2015).

CMS' Health Care Innovation Awards

The objective of CMS' Health Care Innovation Awards program is to engage a broad set of innovation partners to identify and test new care delivery and payment models that originate in the field. The program also supports innovators who can rapidly deploy care improvement models through new ventures or expansion of existing efforts to new populations of patients, in conjunction with other public and private sector partners (CMS Health Care Innovation Awards, 2015).

In the summer of 2012, TransforMED received an award for a primary care redesign project across 15 communities to support care coordination among PCMHs, specialty practices, and hospitals, by creating "medical neighborhoods" (CMS Health Care Innovation Awards, 2015). Owensboro Health Regional Hospital in Kentucky partnered with TransforMED and 14 other participating health systems to test TransforMED's PCMH model and report on quality measures, cost reductions, and patient satisfaction. The project concluded in June 2015 showing positive results, and CMS is currently conducting an independent evaluation.

CMS' Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration

Kentucky operated 7 of the 434 participating sites involved in the FQHC Advanced Primary Care Practice Demonstration funded by the Center for Medicare & Medicaid Innovation (CMMI) that concluded on October 31, 2014 (CMS FQHC, 2015). This demonstration project, operated by CMS in partnership with the Health Resources Services Administration (HRSA), tested the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients. Participating FQHCs were expected to achieve Level 3 PCMH recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. CMS is currently analyzing the demonstration data and developing an independent final report.

University of Kentucky (UK) Kentucky Regional Extension Center (REC) PCMH Practice Transformation Model

The UK Kentucky REC offers an advanced model for practice coaching and technical assistance for practices across the Commonwealth that are implementing PCMH. Through self-reported information, the Kentucky REC has helped five practice sites achieve Level 3 NCQA PCMH recognition and two receive Level 2 NCQA PCMH recognition. Currently, the Kentucky REC is providing support to more than 50 additional practices with NCQA PCMH recognition. The Kentucky REC

has contracts with the Kentucky Primary Care Association and several large health systems, as well as independent practices to support practice transformation and PCMH recognition.

Anthem Enhanced Personal Health Care (EPHC) Model

As the largest commercial payer operating in Kentucky, Anthem launched its EPHC program in early 2014. This program represents the organization's comprehensive, long-term strategy to migrate from a volume-based to a value-based health care model by empowering PCPs to engage in comprehensive primary care functions to move toward a coordinated, evidence-based care model (Anthem, 2015). The EPHC program includes value-based payment, aligns financial incentives, and provides financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach, and quality improvement. To participate in the shared savings component of the program, providers must meet quality performance goals, which include quality standards established by organizations such as the NCQA, the American Diabetes Association, the American Academy of Pediatrics, and others.

As of May 2015, approximately 30 percent of PCPs across the Commonwealth participate in value-based contracts that promote patient-centered care through the EPHC program (Anthem, 2015). Anthem expects approximately 168,000 members to be cared for under EPHC in Kentucky by the end of 2015.

Passport Pay-for-Performance Primary Care Program

In addition to Anthem, other private payers operating in Kentucky have transformed primary care programs. For example, the Passport Health Plan enhanced primary care program offers enhanced payments to all of the PCPs that participate in Passport's network in Kentucky. This program extends the enhanced payments made since 2013 under ACA beyond December 31, 2014, and was effective January 1, 2015 with the first enhanced payment distribution from Passport beginning in April 2015 (Passport Health Plan, 2014).

Accountable Care Organization (ACO)

Kentucky providers currently participate in both the Medicare Advanced Payment ACO Model and the Medicare Shared Savings Program funded by CMS.

CMS' Medicare Advance Payment ACO Models

The Medicare Advance Payment Model funded by CMMI is designed for physician-based and rural providers who have come together voluntarily to provide coordinated, high-quality care to their Medicare patients. Kentucky currently operates 3 of the 35 ACOs participating in the Advance Payment ACO Model: Jackson Purchase Medical Associates PSC, Owensboro ACO LLC, and Quality Independent Physicians LLC (CMS Advance Payment ACO Model, 2015). Kentucky's selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure.

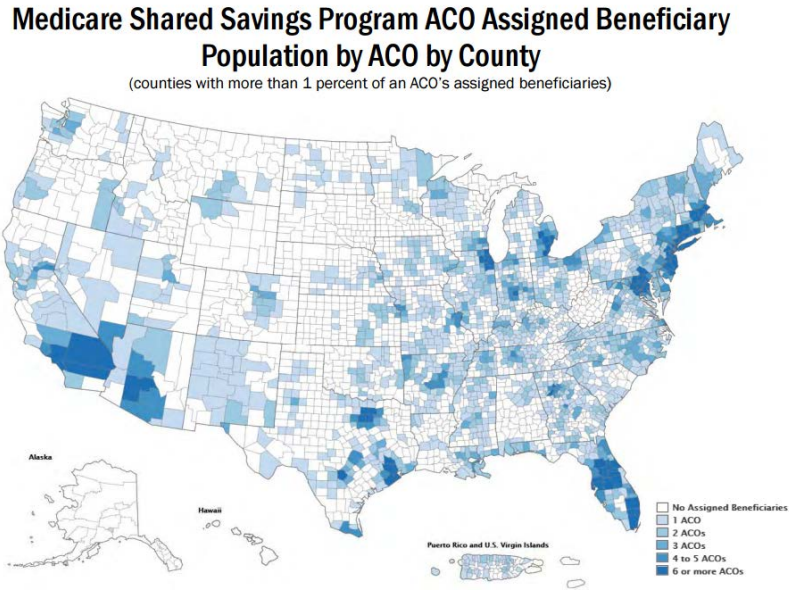

Figure 8: All Medicare Shared Savings Program ACOs (Fast Facts, April 2015)

CMS' Medicare Shared Savings Program

The Medicare Shared Savings Program is a program that helps Medicare fee-for-service (FFS) providers become an ACO. Kentucky providers represent 13 ACOs with service areas both in the Commonwealth and 12 additional states, as depicted in Table 3 (CMS Shared Savings Program, 2015). The Shared Savings Program will reward Kentucky-based ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in a Medicare Shared Savings ACO is voluntary.

For example, the Southern Kentucky Healthcare Alliance (SKHA) is a physician-led ACO currently serving Bullitt, Hardin, Marion, Grayson, Warren, Butler, Edmonson, Hart, Jefferson, and Barren counties. SKHA coordinates health care delivery services for 116 physician providers and serves approximately 15,000 Kentucky consumers. SKHA has participated in the Medicare Shared Savings Program since 2012. In both 2013 and 2014, SKHA was awarded a shared savings payment for reducing spending against a baseline and improving patient conditions.

Medicare Shared Savings ACO[1]	ACO Service Area
Central US ACO, LLC	AR, CO, KY, MO, TN
Deaconess Care Integration, LLC	IL, IN, KY
Jackson Purchase Medical Associates, PSC	IL, KY
MissionPoint Evansville, LLC	IN, KY
Owensboro ACO	IN, KY
Quality Independent Physicians, LLC	IN, KY
The Health Network of Western Kentucky, LLC	IN, KY
KentuckyOne Health Partners, LLC	KY
Pricare ACO, LLC	KY
Southern Kentucky Health Care Alliance	KY
Bluegrass Clinical Partners LLC	KY, LA, TN
Mercy Health Select, LLC	KY, OH
Good Help ACO	KY, OH, NY, SC, VA

Table 3: Kentucky Shared Savings Program ACOs (CMS Shared Savings Program, 2015)

Complex Chronic Condition (CCC) Models

Medicaid Health Home

In 2014, CHFS received a planning grant from CMS to develop a Medicaid Health Home program. In 2010, Section 2703 of ACA created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for Medicaid recipients who have chronic conditions by adding Section 1945 of the Social Security Act (Medicaid Health Homes, 2015). The Health Home model expands on the traditional medical home models developed in many state Medicaid programs. It enhances the coordination and integration of physical and behavioral health care and acute and long-term care services and offers referrals to community-based social services and supports. Health Homes are for Medicaid beneficiaries who have two or more chronic conditions, have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition. Chronic conditions included in the Health Home statute include mental health, substance use disorder, asthma, diabetes, heart disease, and obesity (Medicaid Health Homes, 2015). Kentucky's current planning efforts are focusing on a Health Home program for individuals with an opiate substance use disorder and who are at risk of developing another chronic condition.

Bundled Payment (BP) / Episode of Care (EOC) Initiatives

CMS' Bundled Payments for Care Improvement (BPCI) Initiative

CMS' BPCI is comprised of four broadly defined models of care that link payments for multiple services that beneficiaries receive during an EOC. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for EOCs.

Kentucky currently has eight pilot sites participating in Model 2 of the BPCI, which focuses specifically on Retrospective Acute Care Hospital Stay plus Post-Acute Care (CMS BPCI, 2015). In Model 2, the EOC includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. Model 2 involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an EOC. Under this payment model, Medicare continues to make FFS payments to providers and suppliers furnishing

services to beneficiaries in Model 2 episodes. The total expenditures for a beneficiary's episode are later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate performance compared to the target price.

In addition to Model 2, Kentucky currently has 15 sites participating in Model 3 of the BPCI initiative, which focuses specifically on Retrospective Post-Acute Care only (CMS BPCI, 2015). The payment model for Model 3 is the same as that of Model 2; however, in Model 3 the EOC is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency. Kentucky does not currently have providers and/or sites participating in Models 1 or 4 of the CMS BPCI initiative.

KentuckyOne Health Episodes of Care Program

KentuckyOne Health is currently operating an EOC program in six KentuckyOne Health hospitals. KentuckyOne Health included multiple provider types in the program's care design process, specifically including orthopedic surgeons, an anesthesiologist, a physical therapist, home health, care managers, skilled nursing facilities, and others. As part of this EOC program, RN Care Managers are meeting scheduled patients at a Joint Academy approximately 30 days before surgery and following the patient 90 days or more post-inpatient discharge. KentuckyOne Health Partners is using the Conifer-Value-Based-Care (CVBC) system to track patients throughout the episode from surgery scheduling through episode discharge. The organization will also use CVBC to track costs as claims are processed. To date, early results are positive and show reductions in hospital length of stay and more patients returning directly to their homes.

Other State-based and Federal Models

Kentucky Emergency Room SMART (Supportive Multidisciplinary Alternatives & Responsible Treatment) Program

Under direction from Governor Beshear in September 2013, CHFS launched an initiative within the Medicaid program that aims to reduce over-utilization of Emergency Rooms (ERs) and leverages the Kentucky Health Information Exchange (KHIE) (ASTHO, 2013). The state chose 16 hospitals that ranged from small to large facilities in both urban and rural areas to participate in the program and form coordinated care teams (CCTs) within these communities to better understand and holistically treat ER "super-utilizers." SMART Partners include the Department for Public Health (DPH); the Department for Medicaid Services (DMS); the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID); the KY Hospital Association (KHA); the KY Health Department Association; and the KY Managed Care Organizations (MCOs).

The Greater Louisville Healthcare Transformation (GLHT) Plan

The Kentuckiana Health Collaborative has developed the Greater Louisville Healthcare Transformation (GLHT) Plan in conjunction with a myriad of key Kentucky stakeholders – payers, hospital systems, health plans, providers, employers, public health, governmental organizations, and community leaders. The goal of GLHT is to create a shared vision among key community stakeholders to reach the Triple Aim Goals of improving quality of care and population health, reducing cost trends, and improving experience for patients and their health care teams in the Greater Louisville area (KY SIM July Workgroup, 2015). In a phased initiative, the GLHT plan selects 20 to 40 primary care practices to participate in practice coaching, shared learning activities, data use training, care coordination/management training, data aggregation and other data services, and enhanced payments. The GLHT plan is currently considering payment reform options similar to those outlined in this plan, including PCMH, ACO, bundled payment initiatives, and episodes of care. GLHT has paused its effort to align with major state efforts, including SIM (KY SIM July Workgroup, 2015).

Medicare Care Choices Model

Announced in June 2015, the CMS Medicare Care Choices Model works to provide a new option for Medicare beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers (CMS Medicare Care Choices, 2015). Under this model, CMS plans to evaluate whether providing hospice services can improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures. Three hospice sites in Kentucky were selected to participate in the Medicare Care Choices Model, including the Hospice of the Bluegrass, Inc.; Mountain Community Hospice; and Mercy Health Partners-Lourdes Inc., Lourdes Hospice.

Existing Population Health Initiatives in Kentucky

While the focus of this draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan* is on proposed payment and service delivery models, it is important to recognize the role of population health improvement in the context of larger health system transformation in Kentucky. In May 2015, CHFS submitted a draft PHIP to CMS as a requirement of SIM. The draft PHIP provided an initial assessment of the gaps in access to care along with the health status disparities Kentucky seeks to address in the Model Design period.

This section reviews the existing population health efforts underway in Kentucky, as described further in the draft PHIP, and establishes the linkage between the Commonwealth's population health goals and goals for health system transformation.

kyhealthnow

A central theme of Kentucky's Model Design will be to leverage and build upon interventions and strategies already underway in the Commonwealth. An example of this strategy is the positioning of Governor Beshear's kyhealthnow initiative, which was announced in February 2014. Kyhealthnow is comprised of statewide goals and strategies designed to significantly advance the health and wellness of Kentucky's citizens, as the overarching set of population health goals the SIM initiatives seek to achieve (kyhealthnow, 2015). In addition to the three key population health focus areas prescribed by CMS and CDC through SIM – tobacco, obesity, and diabetes – kyhealthnow contains four additional focus areas that CHFS plans to use in the design and subsequent measurement of SIM delivery system and payment reform models. These additional population health focus areas are cardiovascular disease, cancer, oral health, and drug overdose/poor mental health days. CHFS recognizes that the SIM reforms must address these identified kyhealthnow priority areas and be designed to impact both the health care delivery system and the underlying social determinants of health that contribute to these seven prioritized health conditions currently impacting Kentuckians.

Figure 9: kyhealthnow

Unbridled Health

In addition to kyhealthnow, the Commonwealth has developed a Coordinated Chronic Disease Prevention and Health Promotion Plan, referred to as Unbridled Health, where the mission is to create a healthier Kentucky through a collaborative, coordinated approach to health promotion and chronic disease prevention and management (Unbridled Health, 2013). Unbridled Health, which launched in 2012, provides a framework in which organizations and individuals can unite as one powerful force to reduce the significant chronic disease burden in Kentucky. As shown in Figure 10, the framework includes policy, systems, and environmental changes that support healthy choices; expanded access to health screenings, and self-management programs; strong linkages among community networks; and research data that are used as a catalyst for change.

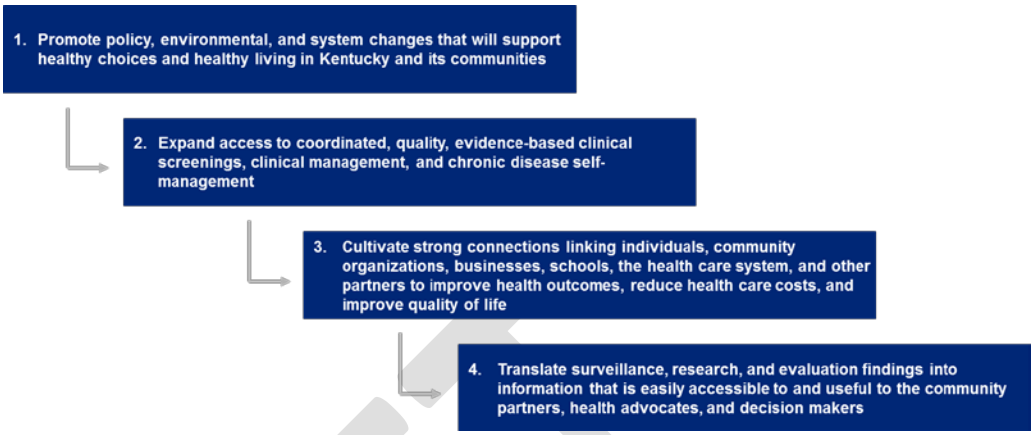

Figure 10: Unbridled Health Strategic Areas

Each strategic area in Unbridled Health provides a variety of action items for potential implementation, as well as health outcome indicators that provide both a baseline from which to begin, and a target to gauge the Commonwealth's progress.

Population Health Improvement Plan (PHIP) Alignment

Together kyhealthnow and Unbridled Health provide a solid foundation from which to address population health through SIM and were positioned as a cohesive strategy in the draft PHIP. Also included in the draft PHIP was a draft set of principles that will be used to guide the design of future service delivery and payment reforms targeted at improving population health that will be outlined in this plan. These principles are also being used in the SIM workgroups to identify the necessary HIT infrastructure, legal, policy, and regulatory levers, and workforce needs to support the SIM reforms. The following principles have been identified as important elements for the proposed SIM delivery system and payment reforms to consider, which may be refined further as work on the Model Design continues:

- Be evidence-based and data-driven
- Promote administrative simplification
- Be designed to promote multi-payer support
- Promote the inclusion of all populations
- Encourage providers to focus on social determinants of health
- Focus both on process improvements and health outcomes
- Make connections between the health care delivery system and other existing systems
- Increase the focus on prevention
- Encourage consumer engagement and accountability
- Develop a quality strategy that ties initiatives to PHIP goals

Throughout this draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan,* the delivery system reforms and payment methodologies proposed will be linked back to these guiding principles and to the seven population health focus areas of kyhealthnow and therefore the PHIP. This consistent lens focused on population health

improvement measurement and monitoring will be incorporated in each reform that the Commonwealth chooses to pursue in order to design a model that not only improves the quality and cost of care delivery, but also the overall health status of Kentuckians.

Draft Delivery System and Payment Reform Plan

Kentucky's emerging Model Design focuses on providing health care providers and payers operating in the Commonwealth with options for how they can participate in value-based care delivery and payment reform and work towards achieving the Triple Aim of improved health, improved care, and decreased costs.

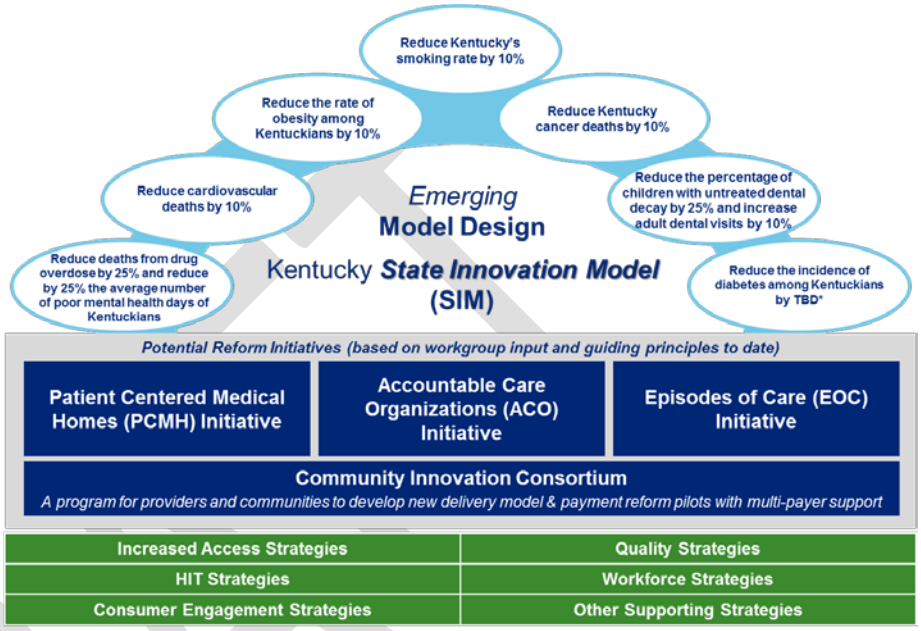

Figure 11: Kentucky's SIM Model Design

The intent of this draft plan is to propose a potential framework for moving forward with a set of initiatives. In addition, this draft provides details concerning how the initiatives could be implemented based on a structure of a CMS SIM Testing Grant. While the initiatives proposed in this plan are mutually supportive and will be depicted in an integrated timeline in the final SHSIP, the expectation is not that providers, payers, and consumers participate in each reform, but rather that these groups voluntarily participate in the value-based models that are suitable for their organizations. The draft will serve as a basis for further discussions with these stakeholder groups as the plan is refined and then discussed with the new Kentucky gubernatorial administration following the November 2015 election.

In developing the draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan*, the Commonwealth considered the complexity of the health care landscape at the local, state, and national levels as the paradigm shifts from volume-based to value-based care. Despite the myriad of considerations inherent in the transformation of health care that is currently underway across the country, the Commonwealth believes it is vitally important to act as a leader in proposing health reform initiatives that are relevant to Kentucky stakeholders. While there will be considerations as we progress toward the goals outlined in this document, Kentucky is committed to providing leadership and support to consumers, providers, and payers and to working together with them to achieve the overarching goal of improving the health of Kentucky's residents.

There are four (4) interconnected delivery system and payment reform components included in the draft plan. The **PCMH** component of Kentucky's emerging Model Design concentrates on transforming primary care, both operationally and clinically, throughout the state, while the **ACO** component represents a multi-payer strategy to make similar changes at the level of the system of care and to impact broad payer populations. Targeted specifically at payment reform, the **EOC** component focuses on creating new, evidence-based structures for managing EOCs more efficiently and realizing savings within the system, while encouraging better coordination of care throughout an episode. The fourth component of Kentucky's proposed model is a concept for a **Community Innovation Consortium** that would engage payers, providers, and communities and organize resources to support sustainable transformation at the community and provider level. All of these components comprise Kentucky's emerging Model Design and the delivery system and payment reforms being developed to support the Commonwealth's population health goals.

This structure has been developed after more than seven months of direct stakeholder input, the formation of guiding principles by stakeholders, and facilitated workgroup sessions targeted at discussing and refining these delivery system and payment reform strategies. This *Value-based Health Care Delivery and Payment Methodology Transformation Plan* defines the range of care delivery models and payment reforms being considered by CHFS to date and outlines each component's definition, core elements, goals, rollout timeline, and implementation roadmap.

The delivery model and payment reforms described in this plan may contain components that require budgetary appropriations and will therefore follow CHFS' mandated budget cycle and standard process, if applicable. The reforms may also require CMS approval in the form of state plan amendments (SPAs) and other state legal and regulatory authorities, and will therefore follow the federal process for these necessary approvals, as applicable.

Delivery System and Payment Reform Goals

While each reform initiative comprising Kentucky's Model Design will have its own unique, initiative-specific Triple Aim-related goals, the Commonwealth has established three overarching SIM goals that it hopes to achieve throughout the design and implementation of the four components outlined in the plan.

1. **Alignment with PHIP Goals**. The population health goals outlined in the PHIP form the foundation for the overall SHSIP. Each payment and service delivery reform is designed to drive Kentucky's population closer to reaching these established goals.
2. **Population Reach.** As outlined in Kentucky's SIM application, the Commonwealth's vision is to implement comprehensive payment reform mechanisms that align economic incentives with population health goals, ideally impacting at least 80 percent of the covered population. Kentucky has formulated a framework for payment reform based on the principles of moving payers and providers toward value-based purchasing, setting evidence-based benchmarks for care, and capturing and using data in a consistent and actionable manner.
3. **Cost Savings.** While a demonstration of cost savings is a required component of the SIM initiative, the Commonwealth believes savings will ultimately result from the more important result of improving population health outcomes. Implemented together, all the reform initiatives detailed in this plan are designed to help the Commonwealth achieve a projected two (2) percent cost savings over a four-year implementation period.

Governance

In order to increase the likelihood that the payment and service delivery reforms being put forth by Kentucky are successful and meet the goals outlined, the Commonwealth is creating a formal governance structure through the implementation of an administrative order, which will be signed by the Secretary of CHFS. This administrative order will establish a select team of individuals to serve on the SIM Governing Body. The SIM Governing Body will be responsible for appointing individuals to serve on the individual Steering Committees. The Secretary of CHFS will consider a broad range of stakeholders for the SIM Governing Body including payers, consumers, providers from across the care continuum, employers, community providers[4], universities, associations, and government agencies.

The administrative order will also establish a Quality Committee. Members of the Quality Committee will be responsible for working with each Steering Committee in an effort to develop a cohesive quality strategy across all the reform initiatives. Committee members will leverage the work done by the Quality Strategy/Metrics workgroup and will specifically focus on applying the guiding principles developed by this workgroup. The Quality Committee overarches each reform initiative. Its role will be to inform the quality strategies of each steering committee, monitor each reform initiative's performance against quality metrics, and report quality outcomes for each reform initiative to the SIM Governing Body.

[4] Defined in this draft as non-licensed and/or non-clinical provider types such as community health workers (CHWs), peer support specialists, and patient navigators

While the Quality Committee will be responsible for developing and monitoring adherence to an overall quality strategy, each respective Steering Committee will use the guiding principles for measure selection that were developed by the Quality Strategy/Metrics workgroup to choose the most appropriate metrics for each reform initiative.

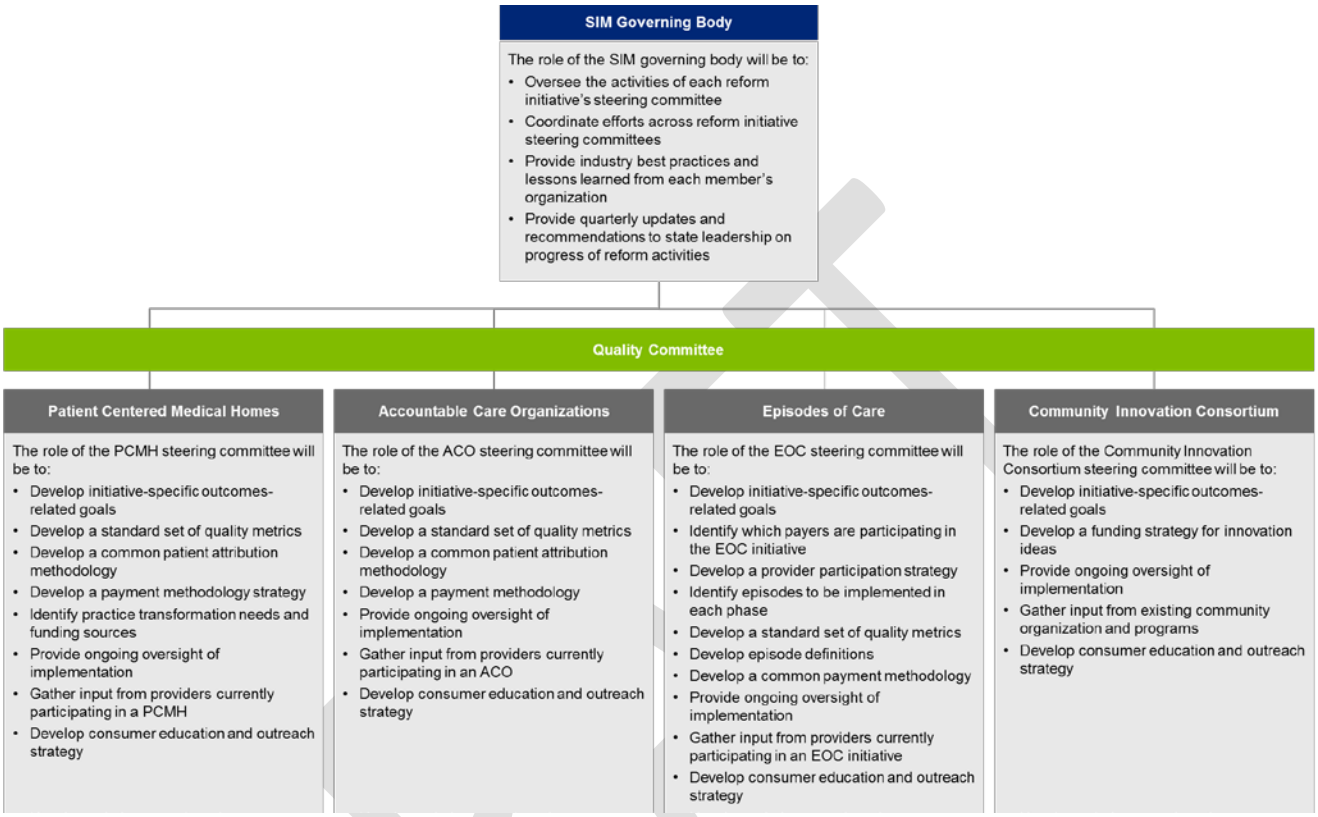

Figure 12: Governance Structure for SIM Payment and Service Delivery Reforms

Consumer Education and Communication Strategy

In order to maximize the impact and reach of the four reform models outlined in this plan, the Steering Committees for each reform will design robust education and outreach strategies to inform consumers of the benefits of receiving care through and participating in the respective value-based care models. This process will begin by identifying the unique communication needs of different subsets of the consumer population and developing the appropriate materials for each population. This education and outreach will be used to inform consumers of the incentives and benefit design strategies contained within each reform component. During this stage of the process, the Steering Committees will also work to develop relationships with community providers and resources, so that they have the means to refer consumers to practices participating in each reform component as needed. It is also anticipated that the SIM Governing Body will work with payers and employers to develop benefit design strategies designed to encourage consumer participation in SIM reform initiatives.

Patient Centered Medical Homes (PCMH) Initiative

Definition

The Commonwealth is proposing to adopt NCQA certification as the baseline standard for PCMH certification. In addition, the Commonwealth believes that each PCMH should meet Kentucky-specific goals and target areas focused on social determinants of health. The PCMH Steering Committee will identify a number of Kentucky-specific components related to PCMH that build on national, evidence-based standards and industry best practices and will identify specific measures related to those components. These measures will be incorporated into the phased PCMH incentive reimbursement structure depicted in Figure 13.

Kentucky is proposing a harmonized multi-payer PCMH payment approach. The approach would fund practices that commit to seek certification. Once certified by NCQA, practices would receive payments that over time have an increasing percentage tied to meeting process and outcome goals.

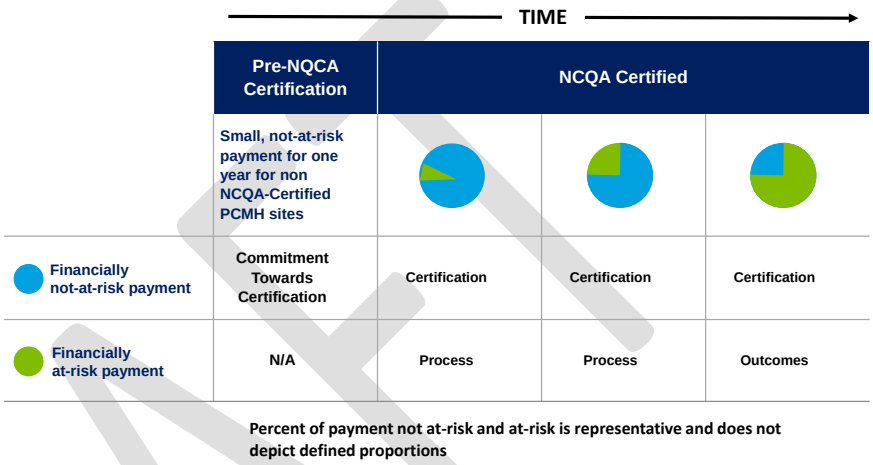

Figure 13: Phased PCMH Payment Strategy

Through collaborative conversations with NCQA at the time of this draft plan, CHFS recognizes the improvements being made to make the process for achieving NCQA certification less challenging for providers and provider organizations. This transitional payment strategy works to support providers who commit to becoming NCQA certified as PCMHs and provides them with a path to achieving this certification as these national improvements continue to emerge.

Throughout the stakeholder engagement process in Kentucky, stakeholders identified several objectives for Kentucky's PCMH initiative. These objectives include:

1. Increase PCP focus on the social determinants of the health issues of their consumers and encourage PCPs to more actively engage and coordinate with available community resources to help meet the needs of their patients
2. Adopt broad and inclusive care teams that have the capability to coordinate the physical, behavioral, and oral health needs of their consumers
3. Increase the number of PCPs in the Commonwealth who are adopting evidence-based PCMH concepts and principles into their practices by encouraging more payers to compensate those PCPs appropriately and by reducing barriers to PCP adoption of the PCMH model by harmonizing, where possible, the requirements for participation and the reporting and measurement requirements across multiple payers
4. Increase the number of Kentuckians choosing to receive their primary care from PCMH providers through the use of incentives and benefit design strategies

Kentucky's PCMH initiative will accomplish these objectives through the use of the stakeholder-defined core elements detailed in the following paragraphs. The core elements identified will be the Commonwealth's priority areas as it begins to introduce the payment and service delivery reform initiatives.

Develop multi-payer PCMH support by aligning PCMH compensation and measures across all payers

A critical success factor in achieving Kentucky's PCMH goals will be the ongoing support of the initiative from multiple payers across the Commonwealth. This will require the Commonwealth to convene payers and reach consensus on key design elements, such as an attribution methodology, quality measures, reimbursement methodology, and certification requirements. The PCMH Steering Committee's primary responsibility will be to obtain consensus around these key design elements.

To demonstrate leadership in the PCMH initiative, DMS plans to work with the Kentucky Employee Health Plan (KEHP) on a PCMH initiative that recognizes the goals, limitations, and existing efforts of each organization during the first year of implementation. This collaborative effort comprised of lessons learned from both groups will serve as the framework with which other payers throughout the state can align when joining in PCMH expansion efforts. Through the PCMH Steering Committee, DMS and KEHP will work to harmonize their approach with other payers supporting PCMH transformation.

Expand the scope and reach of the care team to include a broad array of clinical and non-clinical community service and resource providers

SIM stakeholders have identified the need to encourage PCPs to include a broad range of other clinical and non-clinical professionals in the care team in order to deliver comprehensive, quality care to consumers across the care continuum. For example, the Commonwealth received strong stakeholder feedback that medication adherence monitoring is an effective way to reduce preventable hospital readmissions and costly ER visits. The inclusion of a pharmacist on a PCMH care team could enhance the ability of providers to proactively monitor the medication adherence trends of their consumers, thereby reducing costly medical complications in the future. Stakeholders also emphasized the need to include dentists and other oral health care providers in the PCMH care team, as evidence suggests oral health problems are a significant indicator of other serious health issues and are a particularly significant health challenge in Kentucky. The inclusion of behavioral health (mental health and substance use disorder (SUD)) providers with an emphasis on early childhood care could also improve care coordination between the behavioral and physical health systems, while maintaining an emphasis on prevention.

The Commonwealth will also encourage the engagement of qualified, non-clinical provider types on PCMH care teams, such as peer support specialists and other non-licensed providers. The Commonwealth recognizes the current billing restrictions on some of these non-clinical provider types; however, Kentucky will work with stakeholders to identify an appropriate per member per month (PMPM) reimbursement strategy that reflects the importance of including these individuals on a PCP's care team. The specific provider types that will be targeted will be finalized during the pre-implementation phase of a SIM testing grant by the PCMH Steering Committee under the leadership of CHFS.

Expand the reach of PCMHs to facilitate, coordinate, and efficiently use available, existing community programs and resources

Similar to the concept of expanding the care team to additional provider types, stakeholders have identified the need to work with existing community programs and resources to surround consumers with an array of services and provider types to help improve population outcomes. Kentucky will focus on identifying community resources, such as grocery stores, faith communities, housing support agencies, and local law enforcement to extend care and assistance beyond traditional medical facilities. During the pre-implementation phase, Kentucky will work to establish relationships with these community organizations in order to make it easier for physical, behavioral, and oral health providers to refer consumers to the most appropriate resources. The Commonwealth will also work with PCMHs to develop a strong education and communication strategy that can be used to inform consumers of resources that are available to them.

Engage employers and payers to develop incentive strategies that promote PCMH primary care for their enrollees

To meet its PCMH goals, Kentucky not only needs to increase the number of PCMH primary care practices, but it also needs to attract more individuals to those practices. KEHP will lead in this effort by developing strategies to encourage state employees to use certified PCMH practices. Following the successful implementation of these strategies, the PCMH Steering Committee will convene a meeting of large employers and payers across the Commonwealth, and use the framework established by KEHP to encourage the employers and payers to adopt similar strategies for their employees and enrollees.

Encourage the use of complex chronic condition (CCC) and population management strategies with an emphasis on behavioral health within the PCMH

Average per capita health care spending is significantly higher for individuals with one or more chronic conditions than for those without a chronic condition. As a result, improved care coordination for this population of consumers is at the forefront of health care reform. As part of its PCMH initiative, Kentucky is proposing to develop a CCC component that targets specific populations, those with complex and/or chronic physical and behavioral health comorbid conditions, who would benefit significantly from enhanced care coordination and support.

An example of a CCC initiative is the Medicaid Health Home program which was established by section 2703 of ACA and governed by CMS. The Health Home model expands on the traditional medical home models developed in many state Medicaid programs by enhancing the coordination and integration of physical and behavioral health care and acute and long-term care services and by offering referrals to community-based social services and supports (Kaiser State Health Facts, 2015). Kentucky applied for and received a planning grant to develop a Health Home model for the Medicaid population. This planning initiative has been underway with support from a broad stakeholder group, having made significant progress to define a potential model for a Medicaid Health Home. The planning effort has made strides to define the potential target population, care team, and geographic rollout, among other details. It is anticipated that the Health Home initiative will be rolled out in the second half of 2016.

Goals

The Commonwealth is committed to setting ambitious, yet achievable goals for the introduction of a PCMH initiative that builds on PCMH activity already underway in Kentucky. Specific goals for a PCMH initiative in Kentucky will be developed in the categories outlined below.

- Number of participating sites with the consideration for geographic dispersion (e.g., tracking PCMH expansion by region and encouraging participation in geographic areas with low participation)
- Number of Kentuckians receiving care through a PCMH

In addition to specific targets for the number of participating PCMH sites, as well as Kentuckians reached through a PCMH, the PCMH Steering Committee will develop additional initiative-specific goals focused on consumer experience, quality of care, and improved health outcomes. It will be the responsibility of the PCMH Steering Committee to consider other initiative-specific goals for the PCMH initiative based upon stakeholder input and evidence-based practices.

Targets and Timeline

Phased Approach

The PCMH initiative will occur over a multi-year implementation period. To that effect, the Commonwealth has developed both a high-level rollout timeline, as well as an implementation roadmap for the PCMH initiative. The high-level rollout timeline, shown in Figure 14, depicts the main phases of the PCMH rollout. These include defining the core requirements for PCMHs in Kentucky, developing a framework based on a collaborative PCMH effort between Medicaid and KEHP, implementing a CCC component, and going live with PCMH rollouts across the Commonwealth. Throughout this process,

the Commonwealth will focus on providing the practice transformation support providers need in order to successfully make the transition to a certified PCMH.

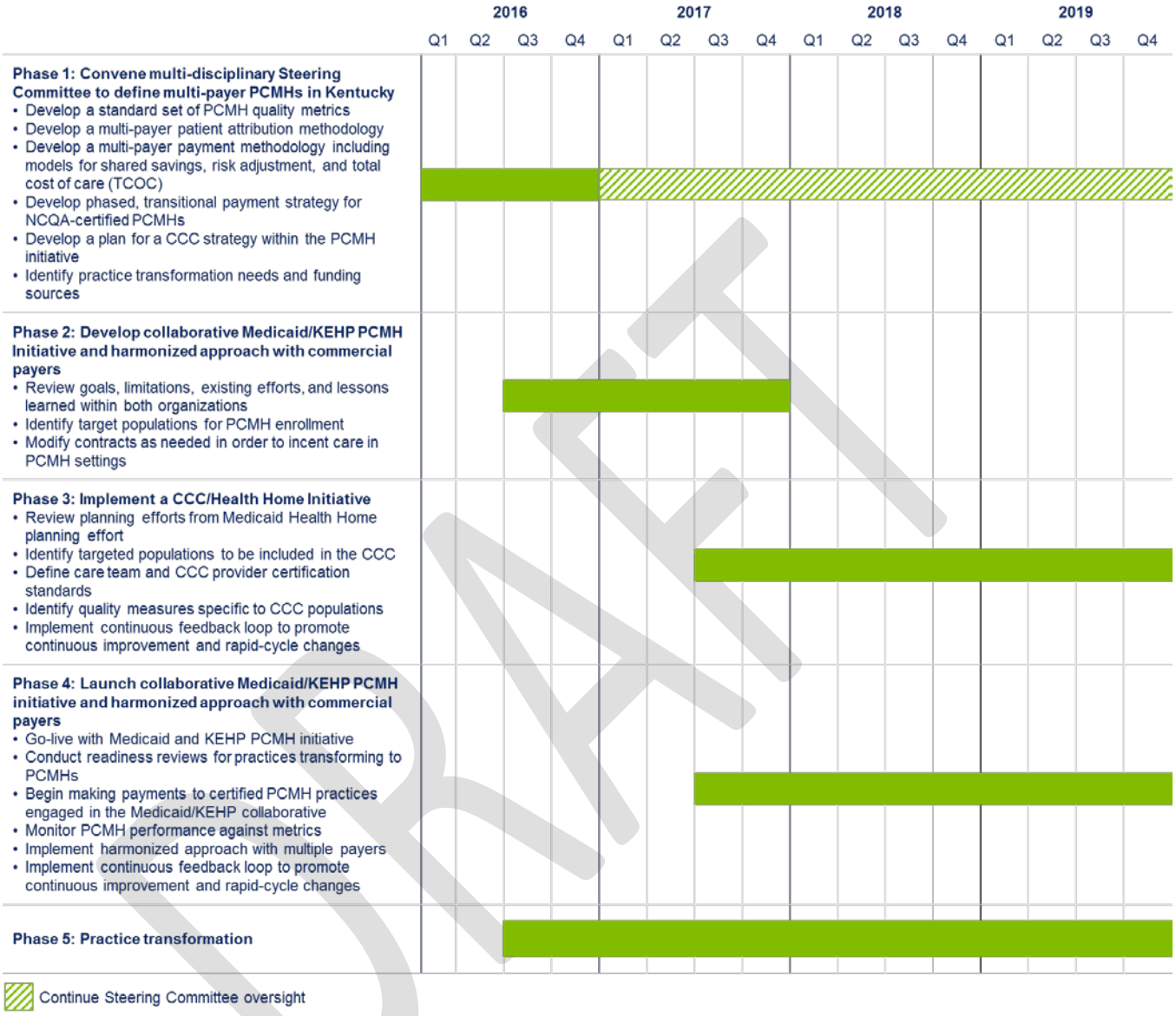

Figure 14: PCMH Rollout Strategy

The implementation roadmap breaks out the high-level activities that will be completed in each subject area during each phase of the rollout. As indicated in Figure 15, the process will begin by developing a detailed design for the PCMH initiative, which will include a harmonized attribution and payment methodology, quality metrics, and certification requirements. These design elements will be developed and agreed upon by the PCMH Steering Committee, which will be formed and spearheaded by CHFS leadership.

	Pre-implementation	Implementation	Operations	Monitor and Improvements
Data Collection & Reporting	• Identify data needed to report on identified quality measures • Define PCMH reporting requirements • Conduct PCMH report design sessions with stakeholder input • Design and finalize PCMH reports	• Develop data collection requirements for stakeholders • Identify baseline quality metrics for reporting	• Collect required data elements for PCMH reporting • Generate PCMH reports as designed	• Identify gaps in data collection and develop strategy for closing gaps • Enhance reporting based on needs identified by providers and end users
Provider Recruitment Support / Practice Transformation	• Identify existing resources to support practice transformation • Develop strategies to augment resources • Identify primary care recruitment targets • Develop process for addressing provider requests and issues	• Respond to provider requests and issues • Proactively engage providers through education and recruitment activities	• Provide ongoing support to practices transforming to become PCMH certified	• Evaluate recruiting and support strategies • Refine provider recruitment and support strategies based on effectiveness of reaching target audience • Reach out to providers and identify additional support areas
Contracting	• Identify contract changes required between state employee health plan administrator and Medicaid Managed Care Organizations (MCOs)	• Execute required contract amendments	• N/A	• Monitor contract compliance and adhere to dispute process already established in contracts
Legal / Regulations	• Identify regulatory and state plan changes required for PCMH implementation • Revise necessary regulations and draft State Plan Amendments (SPAs) • Identify required budget requests	• Obtain approval for revised regulations and SPAs	• N/A	• Modify regulations and state plan as needed based on provider activity and/or revised policy decisions
Technology	• Conduct Health Information Technology (HIT) impact assessment for PCMH implementation • Identify requirements for linking PCMH data with the Kentucky Health Information Exchange (KHIE) and the Kentucky Health Data Trust (KHDT)	• Implement technology infrastructure required for data collection and reporting requirements	• N/A	• Create necessary change orders to correct defects and/or enhance technology systems
Workforce	• Identify scope of care team to include in definition of PCMH • Develop approach to targeting non-traditional providers to include in PCMH care team • Identify minimum data set required to monitor changes in the workforce	• Conduct outreach to educate targeted provider populations • Develop data collection requirements for minimum data set	• Collect required data elements for minimum data set	• Analyze PCMH success against make-up of workforce • Monitor strength and diversity of PCMH care teams across the Commonwealth • Engage additional provider types across Kentucky, as needed
Monitoring and Compliance	• Develop methodology for monitoring PCMH compliance with agreed-upon standards • Design grievance process for out of compliance PCMHs • Develop governance framework for compliance issues	• Conduct readiness reviews for PCMHs about to go live	• Evaluate and decertify out of compliance PCMHs • Administer grievance process for out of compliance PCMHs	• Design and implement recertification process • Update certification guidelines based on provider activity • Monitor adherence to quality metrics and adjust as appropriate to better measure population health outcomes • Monitor and refine attribution methodology, as needed • Monitor and refine payment methodology based on provider and patient outcomes
Communication	• Identify stakeholders and stakeholder communication needs • Develop communication strategy • Develop communication timeline	• Develop and execute communication based on communication strategy and timeline	• Conduct ongoing communication based on communication strategy and timeline	• Determine additional communication needs based on provider and PCMH performance • Refine communication strategy as needed

Figure 15: PCMH Implementation Roadmap

Accountable Care Organizations (ACO) Initiative

Definition

In response to initiatives already underway in Kentucky and feedback that stakeholders provided, along with guiding principles developed throughout the project, Kentucky proposes to expand ACO activity in its effort to improve population health, better coordinate consumer care, and reduce health system costs.

Throughout the stakeholder engagement process in Kentucky, stakeholders identified several important objectives for a Kentucky-specific ACO initiative. These objectives include:

1. Increase the populations enrolled in ACO arrangements by encouraging payers to add their populations to existing ACOs and encouraging payers to support the creation of new ACOs for their populations

2. Reduce administrative and financial barriers that restrict ACO willingness to expand enrolled populations to multiple payers by harmonizing participation, prospective attribution, reporting, and measurement requirements across multiple payers
3. Expand the focus of ACOs to include the social determinants of consumer health issues and the utilization of, and coordination with, community resources by including population health measures in evaluation and shared savings methodologies
4. Expand the scope of ACOs to include more at-risk populations, including individuals with significant physical and/or behavioral health comorbidities, individuals in long-term care (LTC), and individuals receiving long term services and supports (LTSS) through the development of demonstrations for these populations
5. Increase the number of individuals choosing to receive their care through an ACO by the use of incentives and benefit design strategies

Kentucky's ACO initiative will accomplish the above objectives through the use of the stakeholder-defined core elements detailed in the following paragraphs. The core elements identified will be the Commonwealth's priority areas as it begins to introduce the payment and service delivery reform initiatives.

Expand the scope of ACOs to encourage participation across the full continuum of care and focus on behavioral health, public health, and community resources

Throughout the stakeholder engagement process, stakeholders emphasized that coordinated care needs to occur across the full continuum of care. To that end, the Commonwealth will encourage ACOs to target providers across a wide range of specialties, including behavioral health, oral health, and hospice care, among others, in an effort to create the most comprehensive care team possible. Paramount to this success will be engaging community resources and partnering with them to take part in monitoring the health and well-being of consumers outside the traditional clinical setting. The Commonwealth will encourage exploration specifically of home or community-based resources within the development of ACO structures. Additionally, the infusion of Kentucky's population health goals into quality metrics agreed-upon by the ACO Steering Committee and Quality Committee will become central to measuring the performance of ACOs.

Establish a multi-payer, "open-door" policy whereby payers agree to add their populations to an ACO if the ACO desires

Throughout the stakeholder process providers expressed the challenges of delivering care in two different models – FFS and value based care – which reward different behaviors. Stakeholders also indicated the challenges associated with taking on both financial and performance risk for new populations before the necessary infrastructure is in place to successfully manage this risk. To balance these two competing dynamics, Kentucky is proposing to gain payer agreement in order to develop a process for ACO providers that want to add new consumers to their existing ACOs, referred to as an "open-door" policy. A key component of this strategy will be to gain agreement on a harmonized consumer attribution process, which will be developed by the ACO Steering Committee during the pre-implementation phase of a SIM testing period.

An "open-door" policy to implementing ACOs is a framework for payer commitment to the initiative that works to broaden the reach/experiment of ACO effectiveness. Within this framework, as many payers as possible will be in agreement with an ACO approach and express their willingness to engage providers who wish to add new consumers to their existing ACO in order to enhance the provider's ability to leverage the investments and business process changes needed to support their ACO. This framework will promote payers to be open and willing to negotiate with providers to add these populations at the provider's request. The ACO Steering Committee will develop the components of this framework in Phase 1 of the ACO initiative roll out.

Issue a Request for Information (RFI) and subsequent Request for Proposal (RFP) to include individuals receiving Medicaid medical services and LTSS and/or LTC in an ACO

In an effort to solicit innovative ideas and evidence-based approaches from the market for including individuals receiving medical services and LTSS and/or LTC (these populations currently receive coverage through Medicaid FFS) through the Medicaid program in an ACO, the Commonwealth plans to publish a RFI. This RFI will provide Kentucky with an opportunity to evaluate the capabilities of entities that may be interested in expanding or creating an ACO arrangement for these populations. Additionally, the RFI will provide the Commonwealth with an array of perspectives involving best practices around care coordination, quality measurement, consumer engagement, and other pertinent topics that can be used to influence other payment and service delivery reform activities taking place in Kentucky.

The Commonwealth plans to use the RFI results to develop a model to include Medicaid members receiving LTSS and/or LTC in an ACO. The Commonwealth plans to release a RFP to eventually provide the LTSS, LTC, and medical services for these members through an ACO.

Encourage the use of complex chronic condition (CCC) and population management strategies with an emphasis on behavioral health within an ACO

Similar to the PCMH initiative, as part of its ACO initiative, Kentucky is proposing to develop a CCC component that targets specific populations, those with complex and/or chronic physical and behavioral health comorbid conditions, who would benefit significantly from enhanced care coordination and support.

While the CCC focus within the PCMH initiative is the specific Medicaid Health Home program and expansion of that program to a broader range of payers participating in the PCMH model, the ACO initiative will adopt the same CCC and population management principles with an emphasis on behavioral health consumers. As part of the design of the ACO initiative, the ACO Steering Committee will encourage participating payers to adopt CCC and population management strategies through the adoption of performance measures that can be positively impacted by improved care coordination of individuals with complex comorbid conditions.

Goals

The Commonwealth is committed to setting ambitious, yet achievable goals for the introduction of an ACO initiative that builds on ACO activity already underway in Kentucky. Specific goals for an ACO initiative in Kentucky will be developed in the categories outlined below.

- Number of payers involved
- Number of participating providers with the consideration for geographic dispersion (e.g., tracking ACO participation by region and encouraging participation in geographic areas with low participation, and the inclusive of multiple provider types)
- Number of Kentuckians receiving care through an ACO

In addition to specific targets for the number of participating payers and providers, as well as Kentuckians reached through an ACO, the ACO Steering Committee will develop additional initiative-specific goals focused on improved consumer experience and quality of care and health outcomes achieved through an ACO model. The ACO Steering Committee will be responsible for considering other initiative-specific goals for the ACO initiative based upon stakeholder input and evidence-based practices.

Targets and Timeline

Phased Approach

The approach to achieving the ACO goals outlined will occur over a multi-year implementation period. To that effect, the Commonwealth has developed both a high-level rollout timeline, as well as an implementation roadmap for the ACO initiative. The high-level rollout timeline shown in Figure 16 depicts the four main phases of the ACO rollout. These include: (1) defining the core requirements for ACOs in Kentucky; (2) encouraging an open-door policy among existing ACOs and providers interested in joining an ACO; (3) adding more at-risk populations, such as individuals receiving LTSS services, to ACOs; and (4) launching a Medicaid ACO for the LTSS/LTC populations.

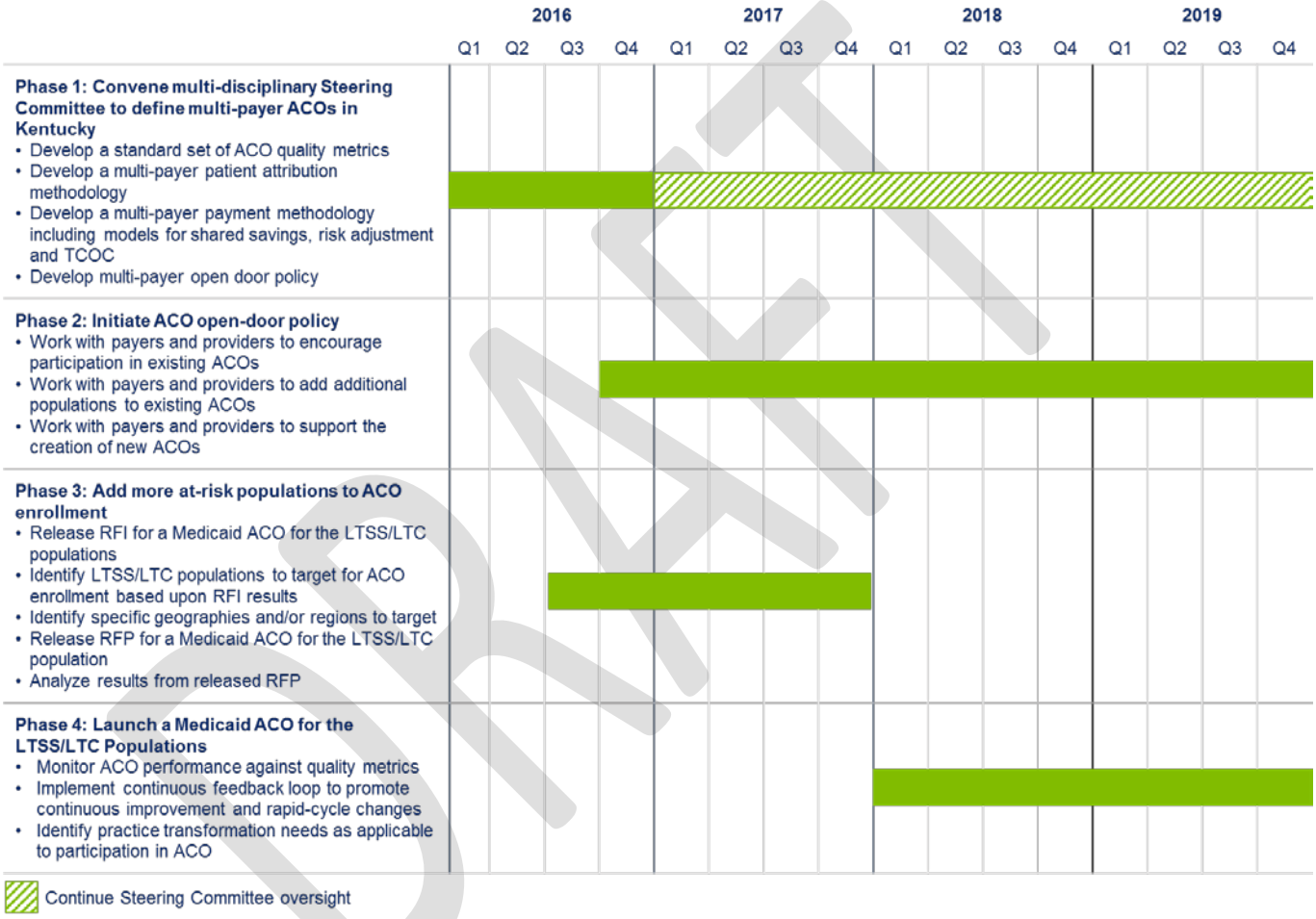

Figure 16: ACO Rollout Strategy

The implementation roadmap breaks out the high-level activities in each subject area during each phase of the rollout. As indicated in Figure 17, the process will begin by developing a detailed design for the ACO initiative, which will include an attribution and payment methodology, as well as quality metrics. These design elements will be developed and agreed upon by the ACO Steering Committee, which will be formed and spearheaded by leadership in CHFS.

	Pre-implementation	Implementation	Operations	Monitor and Improvements
Data Collection & Reporting	• Identify data needed to report on identified quality measures • Define ACO reporting requirements • Conduct ACO report design sessions with stakeholder input • Design and finalize ACO reports	• Develop data collection requirements for stakeholders • Identify baseline quality metrics for reporting	• Collect required data elements for ACO reporting • Generate ACO reports as designed	• Identify gaps in data collection and develop strategy for closing gaps • Enhance reporting based on needs identified by providers and end users
Provider Recruitment Support / Practice Transformation	• Identify existing resources to support practice transformation • Develop strategies to augment resources • Identify provider type targets to be included in ACOs • Develop process for addressing ACO requests and issues	• Respond to ACO requests and issues • Proactively engage targeted provider types through education and recruitment activities	• Provide ongoing support to ACOs	• Evaluate recruiting and support strategies • Refine recruitment and support strategies based on effectiveness of reaching target audience • Reach out to providers and ACOs to identify additional support areas
Contracting	• Identify contract changes required across potential ACO participants	• Execute required contract amendments	• N/A	• Monitor contract compliance and adhere to dispute process already established in contracts
Legal / Regulations	• Identify regulatory and state plan changes required for ACO implementation • Revise necessary regulations and draft SPAs • Identify required budget requests	• Obtain approval for revised regulations and SPAs	• N/A	• Modify regulations and state plan as needed based on provider activity and/or revised policy decisions
Technology	• Conduct HIT impact assessment for ACO implementation • Identify requirements for linking ACO data with KHIE and KHDT	• Implement technology infrastructure required for data collection and reporting requirements	• N/A	• Create necessary change orders to correct defects and/or enhance technology systems
Workforce	• Identify scope of provider types to include in ACO care team • Develop approach to targeting non-traditional provider types in the ACO care team • Identify minimum data set required to monitor changes in the workforce	• Conduct outreach to educate targeted provider types • Develop data collection requirements for minimum data set	• Collect required data elements for minimum data set	• Analyze ACO success against make-up of workforce • Monitor strength and diversity of ACO care teams across the Commonwealth • Engage additional provider types across Kentucky, as needed
Monitoring and Compliance	• Develop methodology for monitoring ACO compliance with agreed-upon standards • Design grievance process for out of compliance ACOs • Develop governance framework for compliance issues	• Conduct readiness reviews for ACOs about to go live	• Administer grievance process for out of compliance ACOs	• Monitor adherence to quality metrics and adjust as appropriate to better measure population health outcomes • Monitor and refine attribution methodology, as needed • Monitor and refine payment methodology based on provider and patient outcomes
Communication	• Identify stakeholders and stakeholder communication needs • Develop communication strategy • Develop communication timeline	• Develop and execute communication based on communication strategy and timeline	• Conduct ongoing communication based on communication strategy and timeline	• Determine additional communication needs based on provider and ACO performance • Refine communication strategy as needed

Figure 17: ACO Implementation Roadmap

Episodes of Care (EOCs) Initiative

Definition

Recognizing the direction CMS has provided with various EOC initiatives, along with efforts underway in nearby states, the Commonwealth and SIM stakeholders have identified the potential to align elements of the payment reform strategy to focus on the implementation of a Kentucky-specific set of EOCs over the course of the SIM implementation period. The Commonwealth believes that EOCs can be a potential entry point for providers making the transition to value-based care who may not yet be prepared to take on performance and financial risk for the total cost of care for broad population groups.

Throughout the stakeholder engagement process in Kentucky, stakeholders identified several important objectives for a Kentucky-specific EOC initiative. These objectives include:

1. Increase the number of episodes covered under an EOC initiative by encouraging payers to support providers who wish to include their populations in the program

2. Encourage the number of episodes covered under an EOC initiative by harmonizing participation, attribution reporting, data sharing reporting, and measurement requirements across multiple payers
3. Increase the use of EOCs by developing a collaborative Medicaid/KEHP EOC demonstration
4. Promote the adoption of the EOC model where providers continue to bill for their services through a fee-for-service model with performance and financial risk held by the EOC coordinating entity.

Kentucky's EOC initiative will accomplish these objectives through the use of the stakeholder-defined core elements detailed in the following paragraphs. The core elements identified will be the Commonwealth's priority areas as it begins to introduce the payment and service delivery reform initiatives.

Review and leverage outcomes, challenges, and successes of EOCs used in surrounding SIM states and Medicare, and develop a roadmap for the deliberate, phased implementation of Kentucky-specific, data-driven EOCs

During the pre-implementation period of a SIM testing grant, the Commonwealth will identify states with a history of implementing EOC initiatives in an effort to identify best practices and bring them to Kentucky's implementation process. CHFS also will convene an EOC Steering Committee during this phase of the project to review the EOC initiatives of neighboring states and Medicare to create alignment and synergies with policies at a national and regional level. An example component would be how the quality and/or outcomes-based measurement strategy in other states and within Medicare is used in developing incentives and/or penalties for participating providers.

This research will be used by the Steering Committee to develop a thorough roadmap that outlines the specific episodes that will be implemented, the length of the episode, services to be included in the episode, a detailed reimbursement methodology, and the lead provider who will be responsible for managing the consumer's care throughout the episode. The intent of the roadmap is to give the time needed to modify existing business processes and technology systems to support the successful transition to a payment system incorporating EOCs to reward improvements in consumer experience, quality of care, improved health outcomes, and reductions in the cost of care.

Establish a multi-payer, "open-door" policy where payers agree to implement EOCs at the request of providers

Kentucky will encourage payers across the Commonwealth to align with its proposed phased approach to implementing EOCs. The Commonwealth recognizes that providers need to balance the desire to have a single operating and clinical model as they transition to a value-based payment environment with their capacity to accept additional performance risk. To address this challenging dynamic, the Commonwealth will convene an EOC Steering Committee to create a process for providers to request adding additional payer populations to their existing EOC initiatives.

An "open-door" policy to implementing EOCs is a framework for payer commitment to the initiative that works to broaden the reach/experiment of EOC effectiveness. Within this framework, as many payers as possible will be in agreement with EOCs and express their willingness to engage providers in EOCs at the provider's request. The EOC Steering Committee will develop the components of this framework and will review and consider the approaches taken by other states.

Create a collaborative EOC demonstration between the KEHP and Medicaid MCOs

EOC initiatives are currently underway in three surrounding states with SIM testing grants, and Medicare continues to increase its emphasis on this payment reform strategy, as evidenced by the testing of mandatory bundled payments for hip and knee replacements through the Comprehensive Care for Joint Replacement (CCJR) model. In keeping with this national and regional focus, the Commonwealth will explore the creation of an EOC demonstration initiative focused on the state employees enrolled in KEHP as well as Medicaid consumers. The focus of such an initiative is better coordination of acute and post-acute services. This demonstration will be developed in a manner that recognizes both the goals and limitations of each organization and is comprised of lessons learned from both groups. In developing this initiative, the

Commonwealth will consider opportunities to harmonize its approach with the initiatives of other states and/or Medicare, while at the same time prioritizing EOCs that would have the most positive impact on Kentucky's population health goals. This demonstration will include the objectives previously defined. Specifically, harmonized participation, attribution reporting, data sharing reporting, and measurement requirements will also be key elements of the Medicaid/KEHP demonstration, as the MCOs and Medicaid Fee-For-Service would use the same methodology and reporting requirements and would create a standardized EOC approach between MCOs and the KEHP. Additional elements within this demonstration will be developed by the EOC Steering Committee, as outlined in Figure 12.

Goals

The Commonwealth is committed to setting ambitious, yet achievable goals for the introduction of an EOC initiative in Kentucky. Specific goals for an EOC initiative in Kentucky will be developed in the categories outlined below.

- Number of episodes covered under an EOC initiative
- Number of providers engaged in an EOC initiative
- Number of participating payers

In addition to specific targets for the number of episodes and participating payers, the EOC Steering Committee will develop additional initiative-specific goals focused on consumer experience, quality of care, and improvements in health outcomes. It will be the responsibility of the EOC Steering Committee to consider other initiative-specific goals for the EOC initiative based upon stakeholder input and evidence-based practices.

Targets and Timeline

Phased Approach

The rollout of increased EOCs in Kentucky will take a phased approach. As shown in Figure 18, there will be five primary phases involved in the rollout of this reform initiative. The first phase will involve creating a detailed roadmap of episodes in order to provide clarity to payers and providers who will need to transform their practices and the identification of potential target EOCs. The second phase will promote transparency within the model by collecting and reporting on those EOCs. The third phase will involve the rollout of a pre-defined set of EOCs, which will be created from the input of multiple stakeholders during the roadmap development process. The fourth phase will evaluate the effectiveness of those episodes implemented in phase three, or "wave one" of the initiative, in order to gather lessons learned and to make improvements before introducing new episodes. The final phase, scheduled to begin in mid-2019, will include the rollout of the additional episodes, or "wave two", identified by the stakeholders and refined by the evaluation of "wave one." This final phase will include a continuous review cycle of the effectiveness of each episode to inform future demonstrations or waves of episodes.

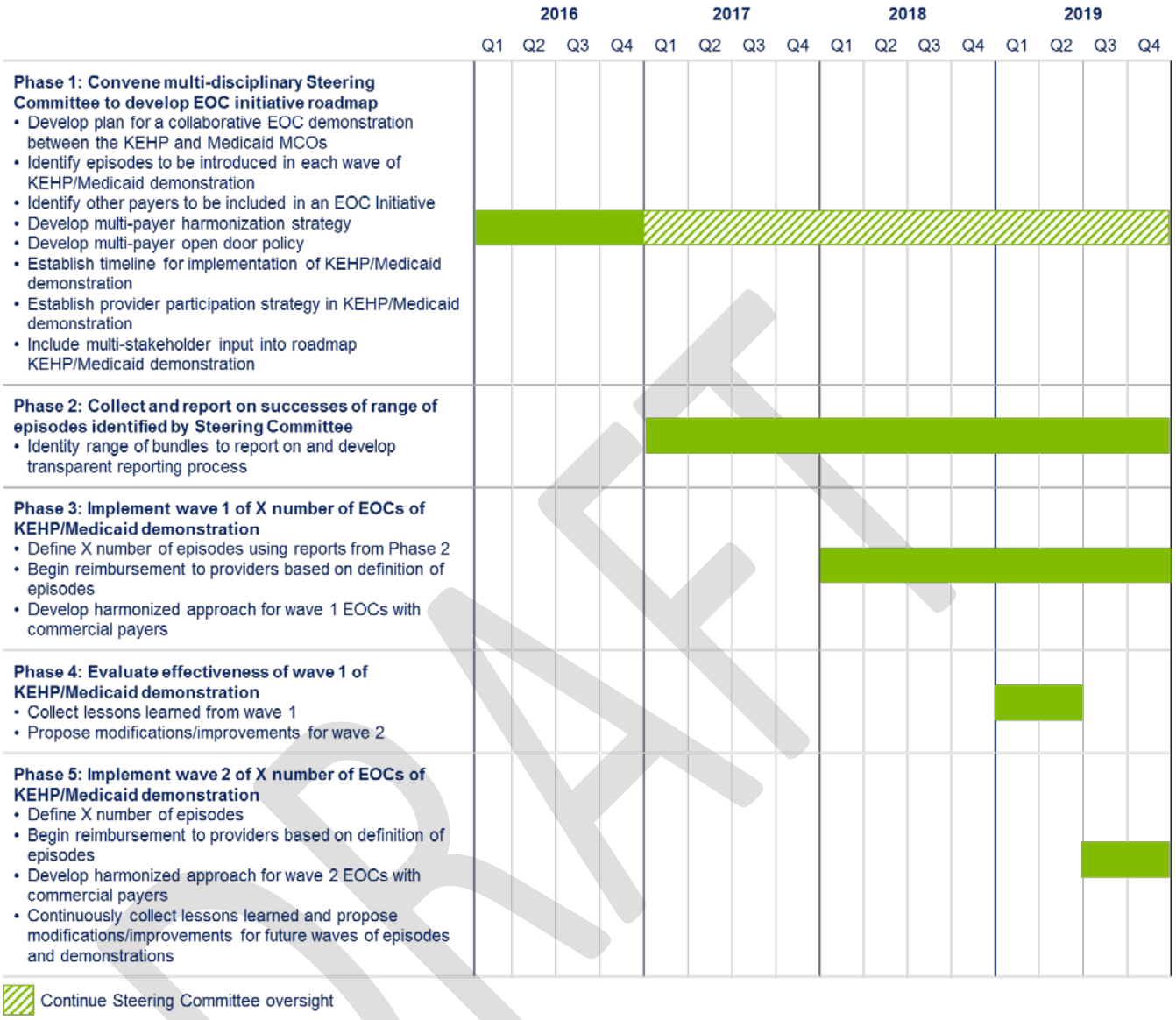

Figure 18: EOC Rollout Strategy

In addition to the high-level rollout strategy depicted in Figure 18, the Commonwealth has also developed an implementation strategy, which outlines the high-level activities that will need to occur across various business domains in order to successfully implement this reform initiative. Figure 19 is a visual representation of this roadmap, and will be the foundation of a more detailed project plan that will be developed during the pre-implementation phase of a SIM testing grant.

	Pre-implementation	Implementation	Operations	Monitor and Improvements
Data Collection & Reporting	• Identify data needed to report on identified quality measures • Define reporting requirements for each EOC • Conduct EOC report design sessions with stakeholder input • Design and finalize EOC reports	• Develop data collection requirements for stakeholders • Identify baseline quality metrics for reporting	• Collect required data elements for EOC reporting • Generate EOC reports as designed	• Identify gaps in data collection and develop strategy for closing gaps • Enhance reporting based on needs identified by providers and end users
Provider Recruitment Support / Practice Transformation	• Identify existing resources to support practice transformation • Develop strategies to augment resources • Identify provider recruitment targets • Develop process for addressing provider requests and issues	• Respond to provider requests and issues • Proactively engage providers through education and recruitment activities	• Provide ongoing support to practices transitioning to EOC usage	• Evaluate recruiting and support strategies • Refine provider recruitment and support strategies based on effectiveness of reaching target audience • Reach out to providers and identify additional support areas
Contracting	• Identify contract changes required to implement episodes	• Execute required contract amendments	• N/A	• Monitor contract compliance and adhere to dispute process already established in contracts
Legal / Regulations	• Identify regulatory and state plan changes required for EOC implementation • Revise necessary regulations and draft SPAs • Identify required budget requests	• Obtain approval for revised regulations and SPAs	• N/A	• Modify regulations and state plan as needed based on provider activity and/or revised policy decisions
Technology	• Conduct HIT impact assessment for EOC implementation • Identify requirements for linking episode of care data with KHIE and KHDT	• Implement technology infrastructure required for data collection and reporting requirements	• N/A	• Create necessary change orders to correct defects and/or enhance technology systems
Monitoring and Compliance	• Develop methodology for monitoring performance of providers participating in EOCs	• Conduct readiness reviews for providers about to implement EOCs	• N/A	• Monitor adherence to quality metrics and adjust as appropriate to better measure population health outcomes • Monitor and refine payment methodology based on provider and patient outcomes
Communication	• Identify stakeholders and stakeholder communication needs • Develop communication strategy • Develop communication timeline	• Develop and execute communication based on communication strategy and timeline	• Conduct ongoing communication based on communication strategy and timeline	• Determine additional communication needs based on provider performance • Refine communication strategy as needed

Figure 19: EOC Implementation Roadmap

A Community Innovation Consortium

Definition

As part of its Model Design, Kentucky will create a forum for communities and providers to develop new delivery system and payment model demonstrations focused on achieving PHIP goals with multi-payer, provider, and consumer leadership and support. The Community Innovation Consortium will be designed to encourage innovations in response to community health needs assessments and other community planning activities. The creation of this consortium is in response to direct feedback from stakeholders and guiding principles developed around the importance of health care solutions occurring at the community level in addition to broad-based system changes.

Kentucky envisions the Community Innovation Consortium to be a structured forum for leaders of community health initiatives to engage payers, providers, and consumers to create partnerships that support sustainable transformation at the community and provider level. The intent of the Consortium is not to duplicate existing community resources or programs, but rather to be flexible in how new innovations are designed to adapt to the current environment. For example, the Consortium could explore expanded participation by the Medicaid MCOs and KEHP in the Greater Louisville Healthcare Transformation Plan, an existing effort to reform the health care system in a specific region. Also, as an example of leveraging an existing, operational program, the Consortium could explore collaboration among the Medicaid MCOs and KEHP with the seven recipients of the Investing in Kentucky's Future (IKF) grant to implement their business plan, which addresses key health issues in Kentucky. These examples represent ways in which payers, providers, and

consumers can leverage existing efforts as part of the Consortium, which is a strategy that can be applied across a broad array of community programs and services.

Goals

The Commonwealth is committed to setting ambitious, yet achievable goals for the rollout of the Community Innovation Consortium in Kentucky. Specific goals for the Community Innovation Consortium will be developed in the following categories:

- Number of participating community-based organizations
- Number of participating payers
- Number of participating providers
- Number of Kentuckians reached by community health initiatives

In addition to these goals, it is anticipated that initiatives that are generated out of the Consortium will have initiative-specific goals related to the population health goals of the PHIP.

Consortium Governance and Design

The Commonwealth will launch the consortium by bringing together the Medicaid MCOs, the KEHP Administrator, and other interested payers to meet on a regular basis to review proposals from community organizations and providers from across Kentucky. The development of the consortium model has been informed by the concepts of similar initiatives underway in other state and Federal programs focused on community innovation. As part of the Community Innovation Consortium Steering Committee, payers, providers, and community organizations will work together to determine how to best support local initiatives that are consistent with the goals of the Transformation Plan and the PHIP. These groups will be responsible for developing specific programmatic and/or financial supports and conduct sustainability planning for each initiative designed by the Consortium. As an example, support could take the form of new payment models or investments in infrastructure that are critical to the success of the community-based initiative.

The Commonwealth will solicit payer, provider, and consumer participation and convene quarterly meetings of the Consortium. The Consortium meetings will both review new proposals and progress reports on existing Consortium projects. The Community Innovation Consortium Steering Committee will also be responsible for assuring that supported initiatives are coordinated with other reform activities.

Timeline

The implementation of a Community Innovation Consortium will occur in two distinct phases. During the initial phase, the framework for the consortium will be established. This involves the development of a specific charter, vision statement, and goals for the consortium and the recruitment of payers, providers, and consumers to participate in the consortium. The second phase will focus on launching partnership initiatives across the Commonwealth.

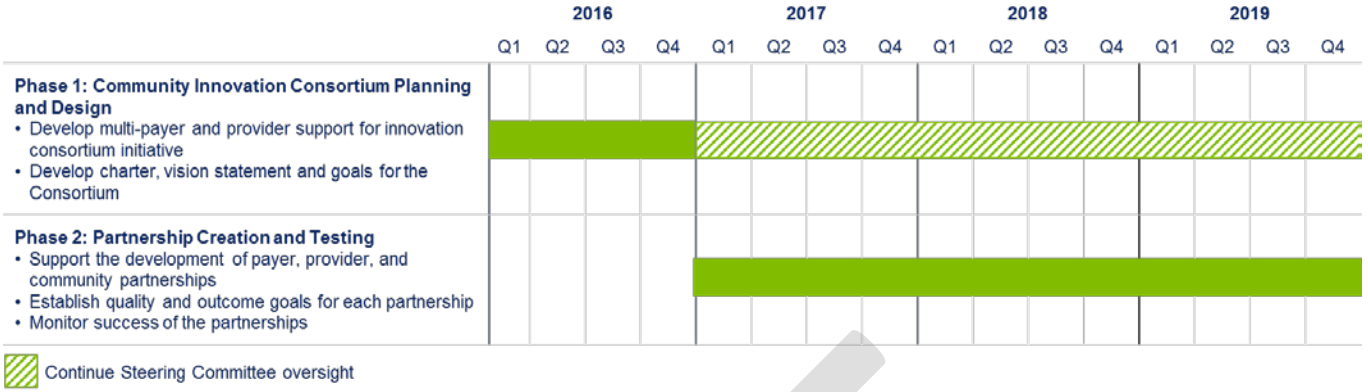

Figure 20: Community Innovation Consortium Rollout Strategy

In addition to the high level rollout strategy for the Community Innovation Consortium initiative, the Commonwealth has developed an implementation roadmap for each phase of the rollout. This roadmap, shown in Figure 21, contains a description of the activities that need to occur within each business area. It will serve as the foundation for a detailed workplan that will be created during the pre-implementation phase of a SIM testing grant.

	Pre-implementation	Implementation	Operations	Monitor and Improvements
Data Collection & Reporting	• Define reporting requirements for partnerships • Design and finalize regional consortium progress reports	• Define specific reporting requirements for each innovation initiative • Identify baseline quality metrics for each innovation initiative	• Collect required data elements • Generate reports as defined during requirements phase	• Identify gaps in data collection and develop strategy for closing gaps • Enhance reporting based on needs identified by end users
Contracting	• Identify contract changes, or new contracts, required to implement innovation ideas, if applicable	• Execute required contract amendments and/or establish new contracts	• N/A	• Monitor contract compliance
Legal / Regulations	• Identify regulatory, waiver and state plan changes required to support innovation ideas • Revise necessary regulations and waivers; draft SPAs	• Obtain approval for revised regulations, waivers, and SPAs	• N/A	• Modify regulations, waivers and state plan as needed based on outcomes of innovation ideas
Technology	• Conduct HIT impact assessment for innovation ideas	• Implement technology infrastructure required for data collection and reporting requirements	• N/A	• Create necessary change orders to correct defects and/or enhance technology systems
Monitoring and Compliance	• Develop methodology for monitoring performance of each innovation idea	• Conduct meetings with each region to educate them on performance requirements	• N/A	• Monitor success of innovation idea based on pre-defined outcome measures, and pursue the idea as suitable
Communication	• Identify stakeholders and stakeholder communication needs • Develop communication strategy • Develop communication timeline	• Develop and execute communication based on communication strategy and timeline	• Conduct ongoing communication based on communication strategy and timeline	• Determine additional communication needs based on regional consortium feedback • Refine communication strategy as needed

Figure 21: Community Innovation Consortium Implementation Roadmap

Supporting Strategies

While the focal points of this draft *Value-based Health Care Delivery and Payment Methodology Transformation Plan* have primarily been discussed in the KY SIM Integrated & Coordinated Care and Payment Reform workgroups, the guiding principles and strategies developed by the Quality Strategy/ Metrics, HIT Infrastructure, and Increased Access workgroups will directly support the components of this draft submission. These elements will be further developed into stand-alone sections of the broader SHSIP, of which this value-based plan is a component, to support the delivery system and payment reforms as they evolve after the completion of this draft section.

For the purpose of this draft, each supporting strategy described below contains core elements agreed upon as necessary and imperative to transform the Commonwealth's health care system. KY SIM stakeholders and CHFS have done an immense amount of work over the past seven months to develop these strategies in support of the SIM initiatives, each of which can be applied to the five proposed reforms outlined in this plan.

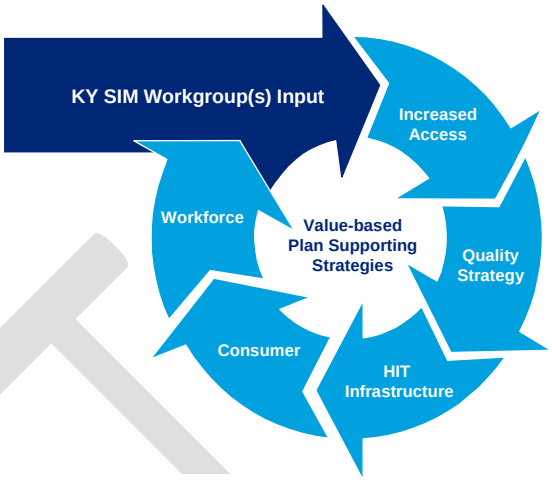

Figure 22: Value-based Plan Supporting Strategies

Increased Access

The KY SIM Increased Access Workgroup was formed to establish a vision for health care delivery system transformation through a broad range of initiatives and the use of regulatory and statutory levers to advance Kentucky's SIM Model Design. The workgroup is working to develop a strategy that incorporates concepts and themes from the PHIP, and is paying particular attention to primary care and preventive services as well as improving rural access to health care services. Over the course of the past seven months, this workgroup has developed a set of core elements that can be included in the Commonwealth's final SHSIP.

For example, the reforms developed as part of SIM would work to increase access to care in the Commonwealth by encouraging the co-location of primary care with specialty care, behavioral health, and oral health services. The expansion of coverage for specific services, including telemedicine and tele-dentistry strategies, and diagnostic and preventive care, was also recognized as a strategy to increase access to care with a focus on prevention.

In addition to exploring co-location and expansion of services, it is clear that there are multiple administrative and/or business processes that can be improved upon to eliminate restrictions on care delivery. For example, KY SIM stakeholders identified the need to revise current same-day Medicaid billing processes to allow for multiple visits across the care spectrum and reduce administrative barriers to telehealth, telemedicine, and tele-dentistry services. Reducing administrative burdens by standardizing and eliminating clinical and/or business process variation wherever possible can increase access to care across the Commonwealth. Several examples of where this standardization can occur to support this strategy include: provider licensure and credentialing, smoking cessation product formularies, smoking cessation reimbursement policies, prior authorization criteria for diabetes-related drugs and products, quality reporting across payers, language/translation services across payers, and others.

These strategies focused on increasing access to care through the SIM reforms will be further developed as Kentucky's model advances, and will be included as singular components in the final SHSIP.

Quality Strategy

The Quality Strategy/Metrics Workgroup was formed to establish a vision and roadmap for more effective measurement of quality and quantifiable improvement in clinical outcomes, and the use of policy levers to advance Kentucky's SIM Model Design. In addition to developing the guiding principles for an overarching quality strategy, as well as the guiding principles for measure selection, the Quality Strategy/Metrics Workgroup has identified several core elements that are focused at the statewide level, overarching each reform. These elements including linking all quality metrics to the PHIP goals and objectives, leveraging existing state and national efforts to consolidate measures and develop a core measure set, standardizing and streamlining quality reporting processes wherever possible, and developing a statewide quality reporting strategy that also measures quality improvement at the community level. This overall strategy will be used across Kentucky's SIM Model Design and will work to inform the individual quality components included within each reform outlined in this plan.

Health Information Technology (HIT)

The KY SIM HIT Infrastructure Workgroup was formed to establish a vision for using HIT to advance Kentucky's SIM Model Design. In doing so, the workgroup is currently working to develop a HIT Plan that provides the data and analytical capability needed to support provider organizations, improve care coordination and delivery, and facilitate the real-time exchange of clinical data in order to improve population health. This HIT Plan will be developed as a component of the SHSIP and will leverage Kentucky's quality health initiative (QHI) and the work of KHIE, while incorporating concepts and themes from the PHIP. Over the course of the past seven months, this workgroup has identified several core elements to comprise an HIT strategy and has begun to answer five key questions that will be used to refine this strategy as the group works toward the development of an HIT Plan.

Specifically, the workgroup recognizes the need to move toward real-time data collection and sharing to increase collaboration within the SIM reforms, as well as the need to develop a more robust infrastructure for data analytics. In addition, SIM can be used to identify ways technology can be used to more actively engage consumers in taking a role in their health and their participation in transforming the Commonwealth's delivery system.

With the support of CHFS' Office of Administrative and Technology Services (OATS) – which administers a broad range of CHFS programs and services from information technology to facilities management and KHIE – the workgroup has developed a five-part HIT Plan Strategy that will be used to develop the broader HIT Plan and support the value-based initiatives outlined in this plan. This strategy focuses on information, analytics, and reporting; engagement technologies; workflow and core application environments; population health management; and interoperability and integration. These strategic issues will be addressed for each of the reforms included in Kentucky's Model Design and will be developed into tactical plans to support the pre-implemention and subsequent rollout of each component.

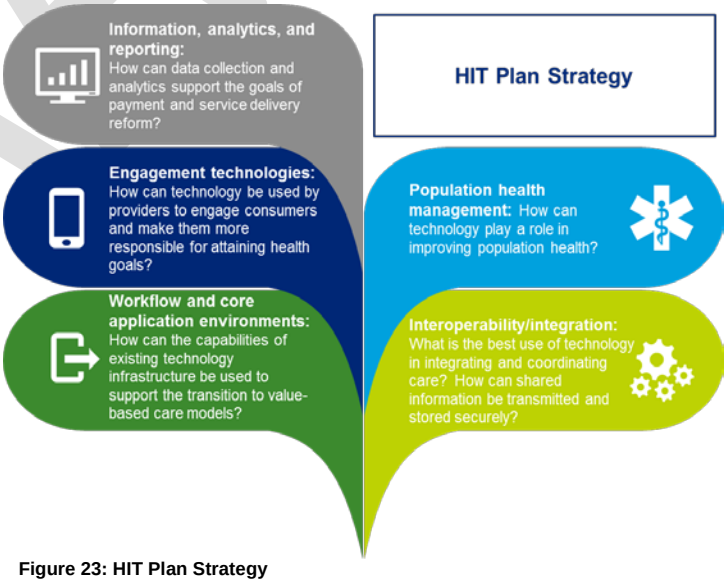

Figure 23: HIT Plan Strategy

Workforce Development

Another task of the Increased Access Workgroup is to explore workforce needs and local resource maximization strategies to support the SIM initiatives. To date, the workgroup has identified existing barriers to workforce development, as well as

potential initiatives to support overcoming each barrier. The workgroup has also developed multiple core elements for a workforce development strategy to support SIM, each of which will be further expanded as CHFS works toward a standalone workforce section in its final SHSIP.

KY SIM stakeholders recognized the need to encourage providers to practice at the top of their scope of practice, and that existing scope of practice regulations could be revised to account for skills and education of provider types. This strategy could support the expanded care team components of the reforms outlined in this plan (e.g., PCMHs, ACOs, and CCC models). To address existing provider recruitment issues, the workgroup identified the need for expanded loan forgiveness programs to other professions (e.g., behavioral health providers and the need to improve the difficulty of clinical placements by promoting health centers as teaching centers). Stakeholders also identified the opportunity to implement early training based upon geographic location and/or communities and to conduct rural family physician identification early (e.g., high school to increase provider recruitment in underserved areas of the Commonwealth).

In addition to recruitment strategies, the workgroup identified strategies to address existing retention issues within the health care workforce, including the need to provide financial support for practice transformation for providers “at-risk” of retirement and to encourage in-state practice and maintenance of community relationships.

The Increased Access Workgroup also identified the opportunity to leverage the data collection strategies within existing workforce development indicatives underway in Kentucky. First, stakeholders identified the opportunity to leverage Area Health Education Center (AHEC) programs to reduce disparities among physicians, APRNs, Pas, etc. Also, as part of the National Governor’s Association (NGA) Policy Academy, the Commonwealth is developing an action plan titled “Building a Transformed Health Workforce: Moving from Planning to Implementation” focused on developing health workforce strategies based on accurate data. This plan contains four core areas: data, redesign of health workforce planning, pipeline, and policy coordination. While this plan is currently in draft form, it outlines vision statements, goals, and strategies in four core areas that could be considered and leveraged in the development of an overall workforce strategy for the SIM initiatives.

These workforce development focused strategies in support of the SIM initiatives will be further developed as Kentucky’s model advances, and will be included as a singular component in the final SHSIP.

Consumer Engagement and Accountability

To date, each KY SIM stakeholder workgroup has identified the need for consumer-specific strategies to support the SIM initiatives that delineates the role of the consumer in transforming the health care delivery system in Kentucky. While the five reforms outlined in this plan contain targeted consumer education and communication strategies, stakeholders recognized the importance of having a consumer-specific strategy for health reform. This strategy would include a broader use of benefit design to encourage consumers to engage in healthier lifestyles and value-based plans. It would focus on individuals with, or at risk of developing, a chronic condition to encourage more active engagement and self-management of health issues. Stakeholders also recognized the importance of increasing consumer health literacy and cultural competency and in developing consumer ownership of their health. Specific consumer strategies will be included in a later draft of the plan based on direct consumer input and further workgroup discussion.

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Conclusion

The conclusion of the *Value-based Health Care Delivery and Payment Methodology Transformation Plan* will be included in the final version of the SHSIP.

Appendix I. Stakeholder Representation

CHFS would like to thank the broad group of Kentucky stakeholders from across the health care landscape who have been engaged in the Model Design process and have both directly and indirectly contributed to the contents of this draft plan. This group of stakeholder organizations is represented in Table 4. CHFS looks forward to continuing its stakeholder engagement process and gathering input into the remaining sections of the SHSIP as it comes together into a cohesive Model Design.

Kentucky SIM Stakeholder Organizations				
AARP Kentucky	Commonwealth Council on Developmental Disabilities	Kentuckiana Regional Planning and Development Agency	Kentucky Youth Advocates	SAS Institute
Abbvie	Commonwealth Health Corporation	Kentuckians for Nursing Home Reform	KentuckyCare	Sayre Christian Village
ABI Case Management	Communicare, Inc.	Kentucky Academy of Family Physicians	KentuckyOne Health	Senior Helpers
Accenture	Community Action Kentucky	Kentucky Association of Counties	Kentucky Diabetes Network	Seven Counties
Access Community Assistance, Inc.	Community Allergy	Kentucky Association of Health Care Facilities	Key Assets Kentucky	Shawnee Christian Healthcare Center
Accessible Home Health Care	Community Farm Alliance	Kentucky Association of Health Plans	Kindred Healthcare	South Health Science
Achieving More, LLC	Community Health Centers of Western Kentucky	Kentucky Association of Health Underwriters	King's Daughters Medical Center	Southeast Kentucky Area Health Education Center
Adanta	Community Hospice	Kentucky Association of Hospice and Palliative Care	Kroger Pharmacy	Southern Kentucky Area Health Education Center
Aetna	Comprehend, Inc.	Kentucky Association of Nurse Anesthetists	Kynect	St. Claire Regional Medical Center
Alliance for a Healthier Generation	Corespring Healthcare Management	Kentucky Association of Private Providers	Lactation Improvement Network of Kentucky	St. Elizabeth Healthcare
Alliant Management Services	Council on Postsecondary Education	Kentucky Association of Regional Program	Leading Age Kentucky	St. Elizabeth Hospital
Almost Family, Inc.	CoventryCares of Kentucky	Kentucky Asthma Partnership	Legislative Research Commission	St. Elizabeth Physicians
American Academy of Pediatrics	Cull & Hayden, PSC	Kentucky Auditor of Public Accounts	Lexington Clinic	St. Mary Hospital
American Cancer Society	Cumberland Family Medical Center	Kentucky Board of Medical Licensure	Lexington VA Medical Center	Sterling Health Solutions
American Heart Association	Cumberland River Behavioral Health	Kentucky Board of Nursing	LifeSkills, Inc.	T.J. Samson Community Hospital
American Lung Association	Cumberland River Homes	Kentucky Cancer Consortium	Lindsey Wilson College	The Adanta Group
American Pharmacy Services Corporation	Dayspring Family Health Care	Kentucky Cancer Foundation	London Women's Care	The Arc of Kentucky
American Stroke Association	Department for Behavioral Health, Developmental and Intellectual Disabilities	Kentucky Cancer Program	Louisville Metro Department of Public Health & Wellness	The Ridge Behavioral Health System
Anthem Blue Cross Blue Shield	Department for Medicaid Services	Kentucky Career Center	Lung Cancer Alliance	Three Rivers District Health Department
Appalachian Regional Healthcare, Inc.	Department for Public Health	Kentucky Center for a Smoke-Free Policy	Manchester Memorial Hospital	Tobacco Control Program
Applied Behavioral Advancements, LLC	Department of Employee Insurance	Kentucky Center for Economic Policy	Marcum and Wallace Memorial Hospital	Top Shelf Lobby
ARCare	Department of Insurance	Kentucky Center for Education and Workforce Statistics	Marshall County Hospital	Triad Health Systems
Arch Care Consultants	Eastern Kentucky Health Care	Kentucky Chamber of Commerce	Masonic Homes of Kentucky	Trinity Rehab
Association of Independent Kentucky Colleges and Universities	Eastern Kentucky University - College of Health Sciences	Kentucky Coalition of Nurse Practitioners and Nurse Midwives	McCarthy Strategic Solutions	Twilights Regional

Auditor's Office	Eastern Kentucky University - Health Services	Kentucky Community and Technical College System	McNary and Associates	Twin Lakes Medical Foundation
Avesis	Eastern State Hospital	Kentucky Council of Churches	Medical Center at Bowling Green	Twin Lakes Regional Medical Center
Babbage CoFounder	Edj Analytics	Kentucky Council on Postsecondary Education	Mental Health America of Kentucky	University of Kentucky Pediatrics
Bailit Health	Ephraim McDowell Health	Kentucky Dental Association	Methodist Hospital	University of Kentucky - Area Health Education Center
Baptist Health	Epic Insurance Solutions	Kentucky Dental Hygienists' Association	Metro United Way	University of Kentucky - Center for Excellence in Rural Health
Baptist Health Medical Group	Fairview Community Health Center	Kentucky Department of Education	meVisit Technologies	University of Kentucky - Center for Health Services Research
Bart Baldwin Consulting	Family Health Centers	Kentucky Department of Health Services	Modern Care, LLC	University of Kentucky - College of Health Sciences
BB&T	Floyd County Health Department	Kentucky Department of Workforce Investment	Molina	University of Kentucky - College of Medicine
Bellarmine University	Foundation for a Healthy Kentucky	Kentucky Disabilities Coalition	Monticello Medical Associates	University of Kentucky - College of Pharmacy
Big Sandy Health	Fountain Avenue United Methodist Church	Kentucky Domestic Violence Association	Mountain Comprehensive Health Corporation	University of Kentucky - College of Public Health
Blessed Assurance Community Services	Four Rivers Behavioral Health	Kentucky Education Cabinet	National Alliance on Mental Illness - Kentucky	University of Kentucky - Department of Rehabilitation Services
Bluegrass Area Development District	Frankfort Regional Medical Center	Kentucky Employees' Health Plan	NeuroRestorative	University of Kentucky - Injury Prevention and Research Center
Bluegrass Case Management	Friedell Committee	Kentucky Equal Justice Center	Newcare of Louisville	University of Kentucky - Institute for Pharmaceutical Outcomes and Policy
Bluegrass Community Health Center	General Electric	Kentucky Health Center Network	Northeast Kentucky Regional Health Information Organization	University of Kentucky - Kentucky Injury Prevention and Research Center
Bluegrass Community Hospital	Grace Community Health Center	Kentucky Health Cooperative	Northern Kentucky University	University of Kentucky - Kentucky TeleCare
Bluegrass Regional	Greater Louisville Medical Society	Kentucky Health Department Association	NorthKey Community Care	University of Kentucky - North Fork Valley Community Health Center
Bluegrass.org	Greater Louisville Project	Kentucky Health Departments Association	Northwest Area Health Education Center	University of Kentucky - University Health Services
Board of Examiners of Psychology	Green River Area Development District	Kentucky Health Information Exchange	Norton Healthcare	University of Kentucky HealthCare
Board of Nursing	Green River District Home Health	Kentucky Heart Disease and Stroke Taskforce	Office of Administrative and Technology Services	University of Kentucky Medical Center
Bourbon Community Hospital	Harrison Memorial Hospital	Kentucky Home Health Association	Office of Health Equity	University of Kentucky Regional Extension Center
Boyle County Health Department	Hazard ARH Regional Medical Center	Kentucky Hospital Association	Office of Health Policy	University of Louisville - Department of Pediatrics
Brain Injury Alliance of Kentucky	Health Care Excel	Kentucky Housing Corporation	Office of Inspector General	University of Louisville - Health Affairs
Cabinet for Health and Family Services	Health Management Resources	Kentucky Medical Association	Operation UNITE	University of Louisville - Institute for Sustainable Health and Optimal Aging
Campaign for Tobacco Free Kids	Health South	Kentucky Mental Health Coalition	Our Lady of Bellefonte Hospital	University of Louisville - Kentucky Cancer Program

Cancer Action Network	Health South Lakeview Rehab Hospital	Kentucky Mountain Health Alliance	Owensboro Health	University of Louisville - School of Dentistry
Capacity Care, Inc.	HealthFirst Bluegrass Community Health Center	Kentucky Nurses Association	Park Duvalle Community Health Center	University of Louisville - School of Medicine
Cardinal Hill Rehabilitation Hospital	HealthFirst Bluegrass Inc.	Kentucky Office of Occupations & Professions	Participation Station	University of Louisville - School of Public Health and Information Sciences
Care at Hand	HealthPoint Family Care	Kentucky Office of Rural Health	Passport Health Plan	University of Louisville - School of Social Work
Care Guide Partners	Heritage Hospice, Inc.	Kentucky Oral Health Program	Path Forward	University of Louisville Physicians
Care Innovations	Highlands Regional	Kentucky Partnership for Families and Children	Pathways, Inc.	University of Pikeville - Kentucky College of Osteopathic Medicine
Carewise Health	Horn and Associates in Rehabilitation, PLLC	Kentucky Personnel Cabinet	Patient Navigation Education & Research Institute	Viable Synergy, LLC
Carroll County Memorial Hospital	Hosparus	Kentucky Pharmacists Association	Pediatric Behavioral and Mental Health Alliance of KY	Walgreens Pharmacy
Casey County Hospital	Hospice Care Plus Inc.	Kentucky Physical Therapy Association	Pennyroyal Healthcare Services	WATCH, Inc.
Catholic Health	Hospice of Hope	Kentucky Primary Care Association	People Plus, Inc.	Wayne County Hospital
Caverna Memorial Hospital	Hospice of Lake Cumberland	Kentucky Protection and Advocacy	Personal Medicine	Wayne's Pharmacy
Center for Accessible Living	Hospice of the Bluegrass	Kentucky Psychiatric Medical Association	Pharmacists Association	WellCare
Center of Excellence in Rural Health	Humana	Kentucky Psychological Association	Planned Parenthood of Kentucky	Wells Fargo
Centers for Disease Control and Prevention	Humana CareSource	Kentucky Public Health Association	Precision Healthcare Delivery	Wendell Foster
Centers for Medicare and Medicaid Services	Independent Opportunities - Lake Cumberland	Kentucky Retirement Board	Prichard Committee	West Kentucky Workforce Board
Central Baptist Hospital Home Health	Industry Partnership Project	Kentucky River Community Care	Primary Care Office	Western Kentucky University
Child Advocacy Today - Legal Clinic	InnovateLTC	Kentucky River Foothills Development Council	PrimaryPlus	Western Kentucky University - Area Health Education Center
Children, Inc.	Inspired Living, LLC	Kentucky Rural Health Association	Public Life Foundation of Owensboro	Westlake Regional Hospital
Christian Care at Home	IntegrityIT	Kentucky Safe Aging Coalition	Purchase Area Development District	Westport Medical
Christian Care Communities	Intel-GE Care Innovations	Kentucky Safety & Health Network	Purchase Area Health Education Center	White House Clinics
Chronic Obstructive Pulmonary Disease (COPD) Coalition	Interdisciplinary Human Development Institute	Kentucky Safety and Prevention Alignment Network	Qsource	Women's Crisis Center
Clover Fork Clinic	James B. Haggin Memorial Hospital	Kentucky School Board Association	Rivendell Behavioral Health Hospital	Workforce Investment
Coalition for the Homeless	Jane Todd Crawford Hospital	Kentucky Self Advocates for Freedom	River Valley Behavioral Health	YMCA of Central Kentucky
Commission for Children with Special Health Care Needs	Juniper Health Inc.	Kentucky Task Force on Hunger and Covering Kentucky Kids and Families Coalition	River Valley Nursing Home	YMCA of Greater Louisville
Commonwealth Alliances	Kaleidoscope, Inc.	Kentucky Tobacco Prevention and Cessation Program	Russell County Hospital	ZirMed
Commonwealth Case Management	Kentuckiana Health Collaborative	Kentucky Voices for Health	Saint Joseph Martin	Zoom Group

Table 4: Kentucky SIM Stakeholders

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